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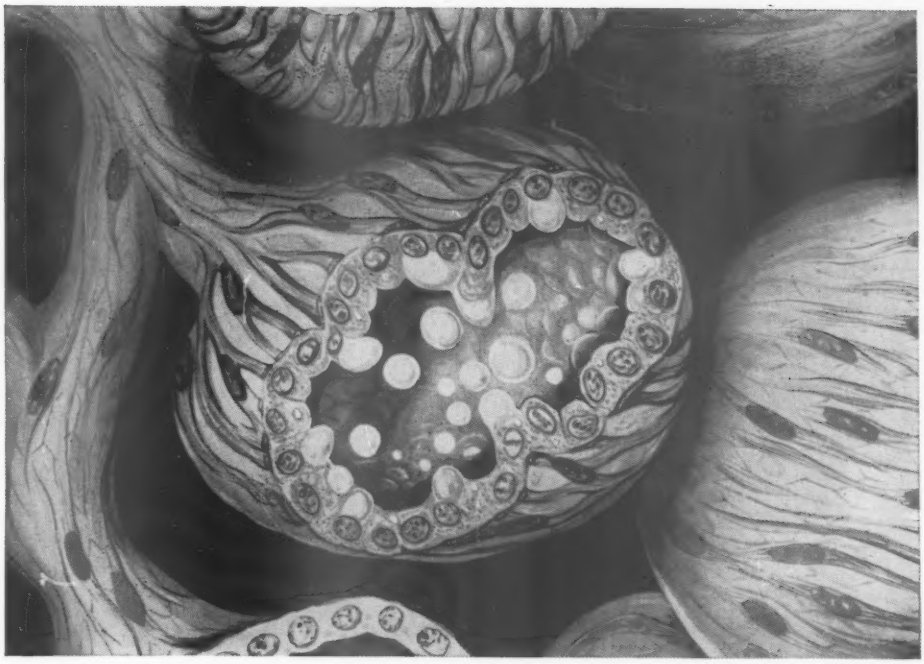

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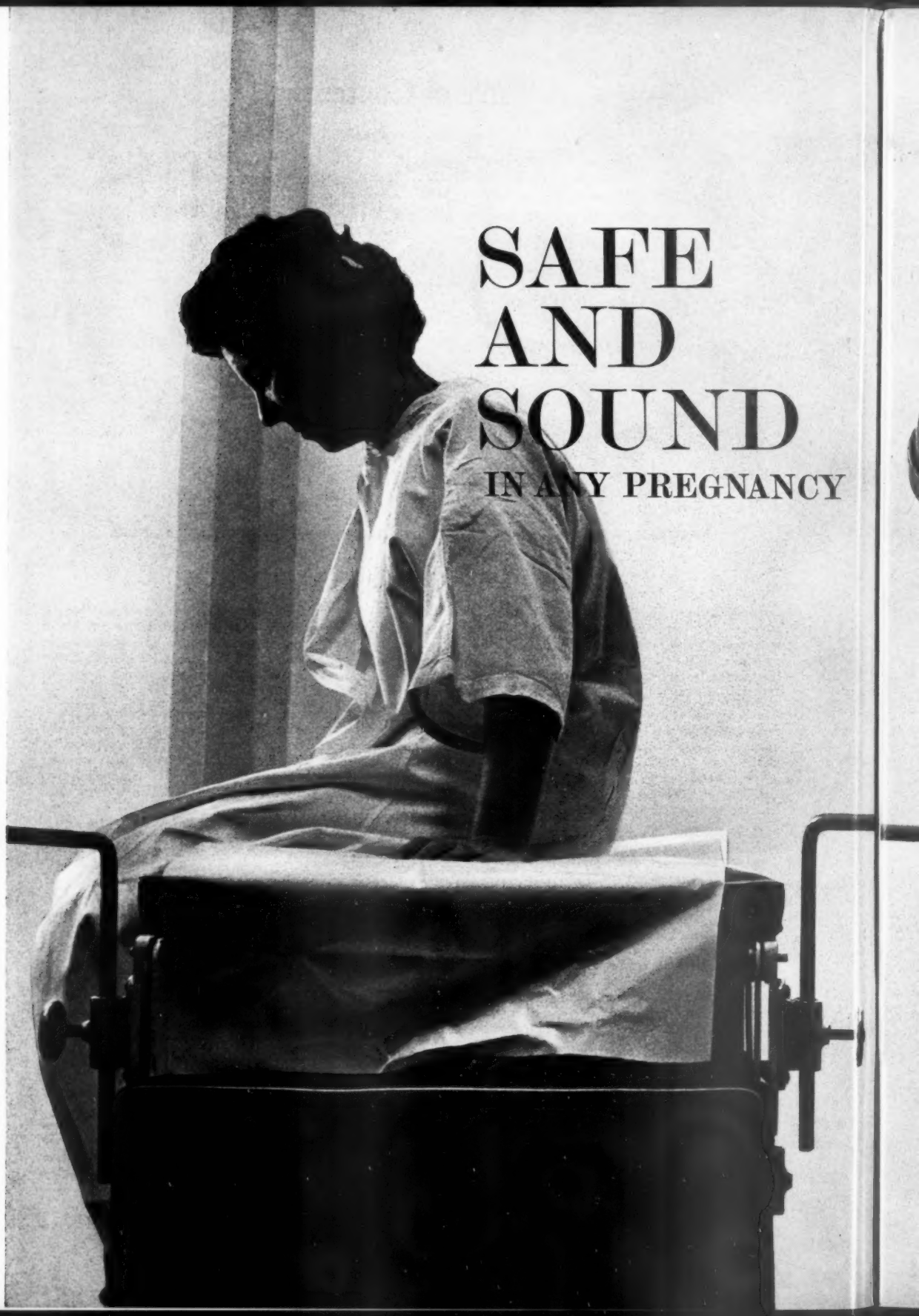
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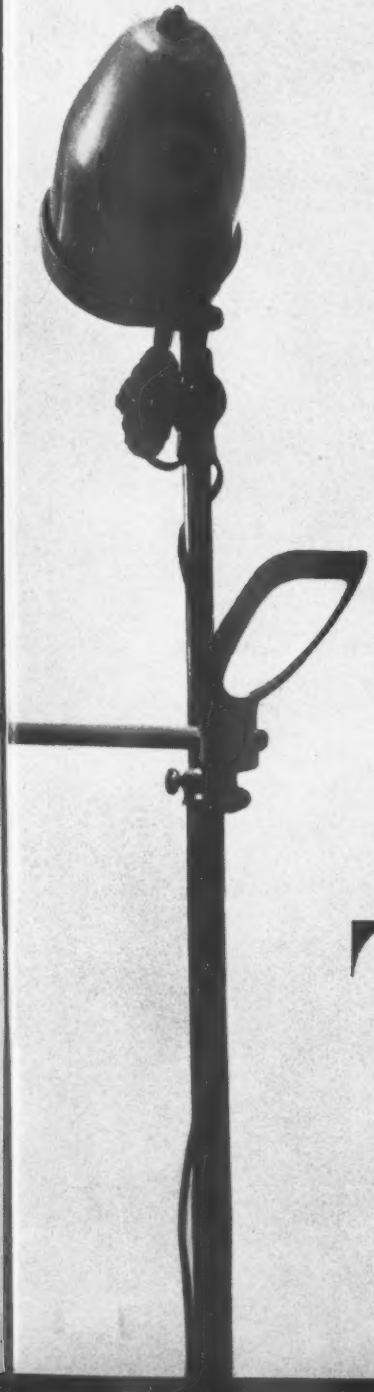

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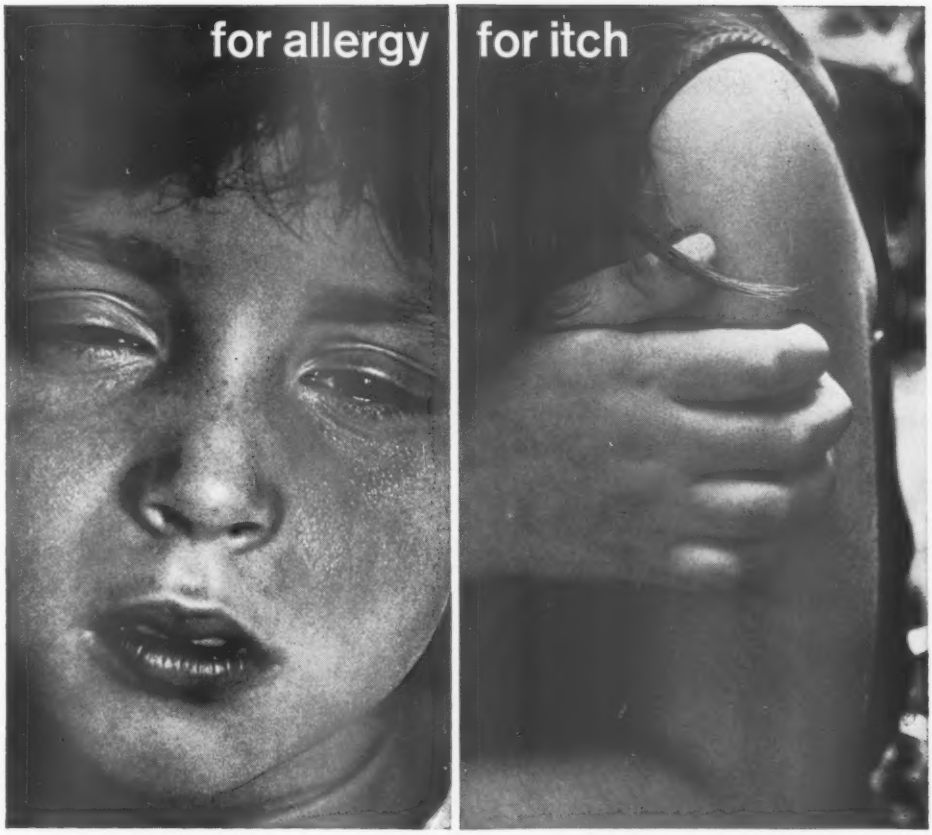

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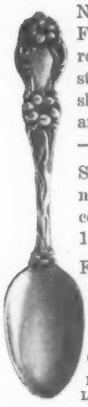

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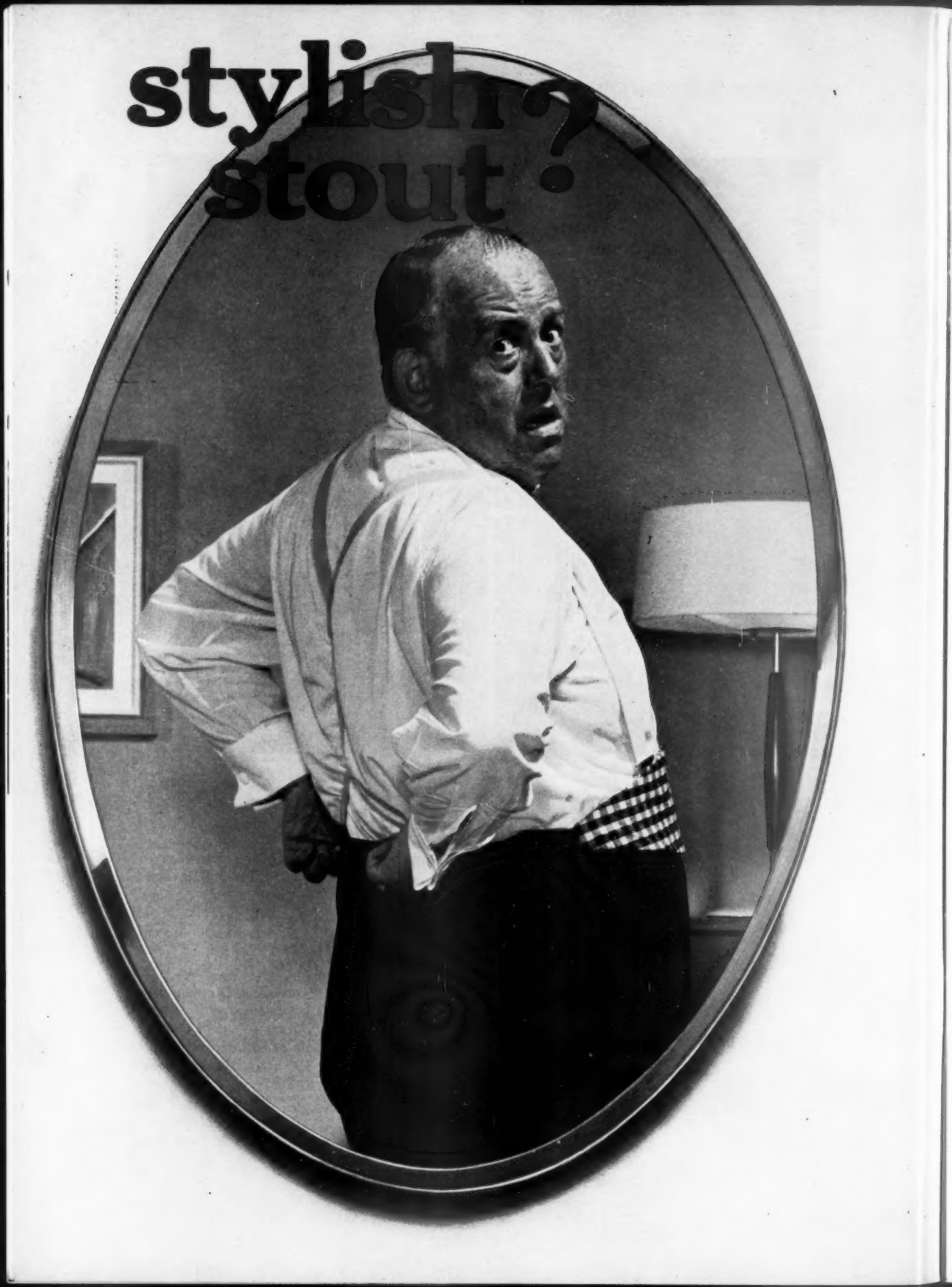
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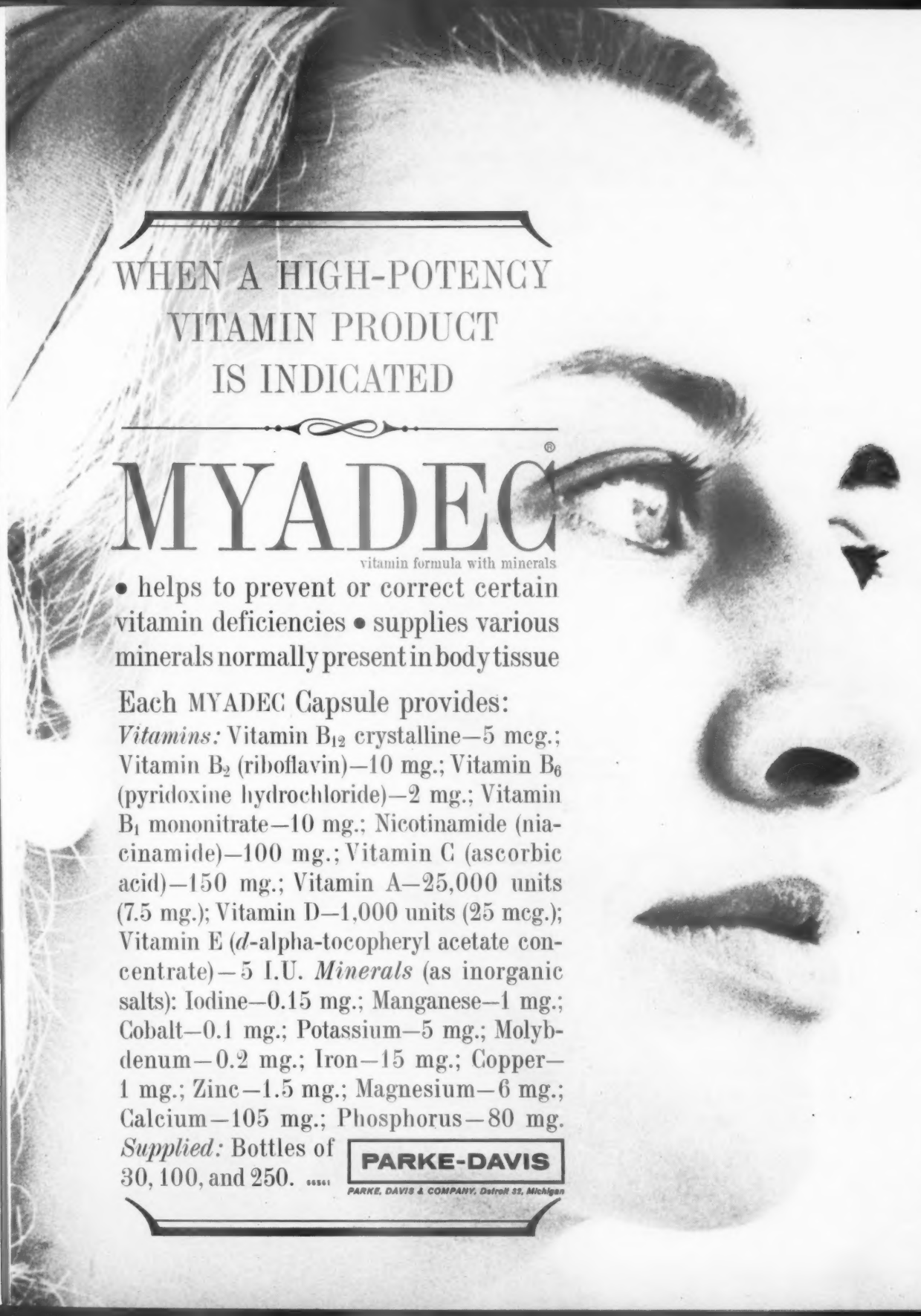

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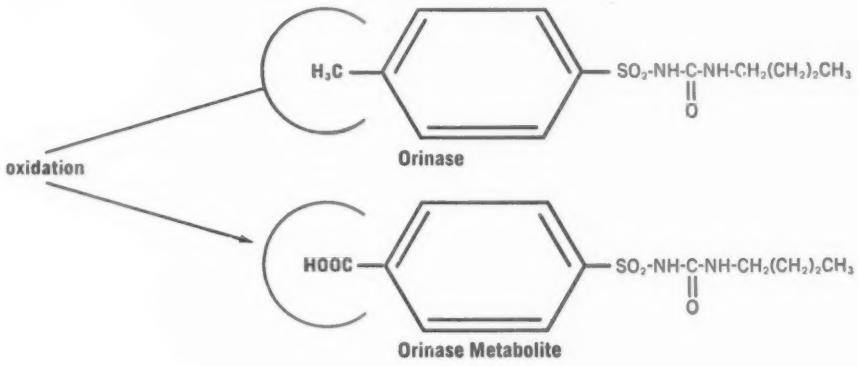
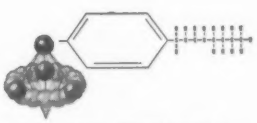
This widely-reported clinical benefit is a function of the exclusive Orinase methyl "governor." Lending itself to ready oxidation (principally, it is thought, a hepatic process), the methyl group ensures prompt metabolic inactivation of the Orinase molecule. What actually happens is that a rapidly- and continuously-excreted carboxy-metabolite is produced that has no hypoglycemic activity at the existing levels.

As a result of the oxidation of its methyl group, Orinase shows a decline in activity soon after it reaches its effective peak in the plasma. Maintenance dosage serves to reduce blood sugar levels to normal, but rarely below that point, and there is no reported problem of accumulation.



Orinase*



An exclusive methyl "governor" minimizes hypoglycemia

Indications and effects: The clinical indication for Orinase is stable diabetes mellitus. Its use brings about the lowering of blood sugar; glycosuria diminishes, and such symptoms as pruritus, polyuria, and polyphagia disappear.

Dosage: There is no fixed regimen for initiating Orinase therapy. A simple and effective method is as follows: *First day*—6 tablets; *second day*—4 tablets; *third day*—2 tablets. The daily dose is then adjusted—raised, lowered or maintained at the two-tablet level, whichever is necessary to maintain optimum control.

Patients receiving insulin (less than 20 units)—discontinue insulin and institute Orinase; (20 to 40 units)—initiate Orinase with a concurrent 30 to 50% reduction in insulin dose with a further careful reduction as response to Orinase is observed; (more than 40 units)—reduce insulin by 20% and initiate Orinase with a further careful reduction in insulin dosage as response to Orinase is observed. In candidates for combined Orinase-insulin therapy, an individualized schedule is usually obtainable during a trial course of two or more weeks.

Contraindications and side effects: Orinase is contraindicated in patients having juvenile or growth-onset, unstable or brittle types of diabetes mellitus; history of diabetic coma, fever, severe trauma or gangrene.

Side effects are mild, transient and limited to approximately 3% of patients. Hypoglycemia and toxic reactions are extremely rare. Hypoglycemia is most likely to occur during the period of transition from insulin to Orinase. Other untoward reactions to Orinase are usually not of a serious nature and consist principally of gastrointestinal disturbances, headache, and variable allergic skin manifestations. The gastrointestinal disturbances (nausea, epigastric fullness, heartburn) and headache appear to be related to the size of the dose, and they frequently disappear when dosage is reduced to maintenance levels or the total daily dose is administered in divided portions after meals. The allergic skin manifestations (pruritus, erythema, and urticarial, morbilliform, or maculopapular eruptions) are transient reactions, which frequently disappear with continued drug administration. However, if the skin reactions persist, Orinase should be discontinued.

Clinical toxicity: Orinase appears to be remarkably free from gross clinical toxicity on the basis of experience accumulated during more than four years of clinical use. Crystalluria or other untoward effects on renal function have not been observed. Long-term studies of hepatic function in humans and experience in over 650,000 diabetics have shown Orinase to be remarkably free of hepatic toxicity. There has been reported only one case of cholestatic jaundice related to Orinase administration, which occurred in a patient with pre-existing liver disease and which rapidly reversed upon discontinuance of the drug.

Each tablet contains:
Tolbutamide ..... 0.5 Gm.

Supplied: In bottles of 50.

*Trademark, Reg. U.S. Pat. Off.—tolbutamide, Upjohn

June, 1961

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The Upjohn Company, Kalamazoo, Michigan

Upjohn

When the stomach has a nervous patient!

BUTIBEL®

antispasmodic/sedative

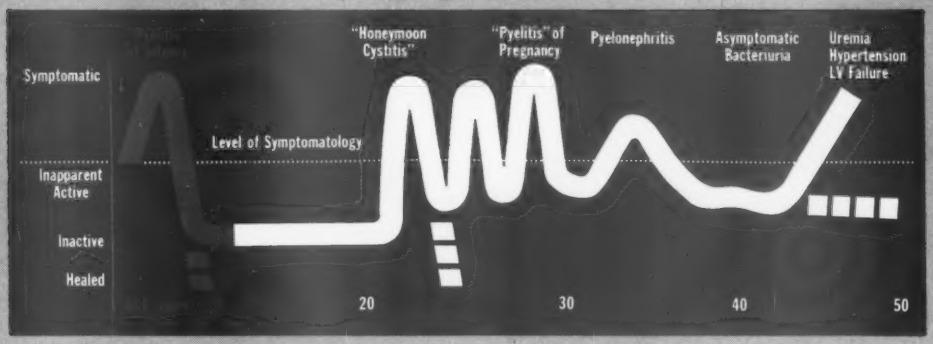
relaxes the tense patient and his jittery stomach...without the sedative "build-up" many patients experience with phenobarbital preparations.

BUTIBEL combines the "time-matched" components—BUTISOL SODIUM® butabarbital sodium 15 mg. and extract of belladonna 15 mg.—each having approximately 5 hours' duration of effect. Thus, with Butibel there is no overlapping sedation, no antispasmodic gap—t.i.d. dosage keeps the patient comfortable without sluggishness.

Available as: BUTIBEL Tablets • Elixir • Prestabs® Butibel R-A (Repeat Action Tablets)

McNEIL LABORATORIES, INC., Fort Washington, Pa.

Natural History of Pyelonephritis



"... the theme that runs through the carefully taken history of most uremic patients with chronic pyelonephritis—the burning on urination of infancy, the chills and fever in childhood, the 'honeymoon' pyelitis, the recurrent urethritis treated so well and often locally—and yet the termination in uremia."[1]

in early childhood—"a potentially fatal warning sign"[2]

The *best* opportunity to eradicate urinary tract infection (and prevent potentially disastrous sequelae) is the *first* opportunity—in the infant and young child.

Furadantin—for a "cure" instead of a "chronic"

In children "a prophylactic regimen of therapy is indicated. . . . The therapy could be compared to the prophylactic treatment of patients whose exacerbation of a rheumatic fever has been controlled."[3] "Continuous prophylactic therapy with nitrofurantoin, at present, is our best modality for the treatment of chronic urinary tract infection."[4]

FURADANTIN DOSAGE FOR CHILDREN: Average dose is 5 to 8 mg. per Kg. (2.3 to 3.6 mg. per lb.) in 4 divided doses daily. A prophylactic dosage of from 1 to 5 mg. per Kg. is recommended for long-term use.[3] After the infection has been controlled, urinalysis and culture at least twice a year are suggested.[3]

SUPPLIED: Oral Suspension, 25 mg. per 5 cc. tsp., readily miscible with water, infant formulas, milk or fruit juices. Tablets, 50 mg. and 100 mg.

REFERENCES: 1. Birchall, R.: Am. Practit. *11*:918, 1960. 2. Stevenson, S. S.: J. Louisiana Med. Soc. *110*:219, 1958. 3. Marshall, M., Jr.: J. Kentucky Med. Assoc. *59*:35, 1961. 4. Johnson, S. H., III, and Marshall, M., Jr.: J. Urol. *82*:162, 1959.

Complete information in package insert or on request to the Medical Director.

EATON LABORATORIES, Division of The Norwich Pharmacal Company, NORWICH, NEW YORK

To cure or control infection throughout the urinary system at every age of life... at every stage of infection

Furadantin®

brand of nitrofurantoin

They Bounce Back Fast with TYLENOL®

acetaminophen

antipyretic / analgesic

He's the same young patient who was feverish and listless yesterday—Tylenol quickly brings fever and discomfort under control.

Tylenol is safe, exceptionally free from side effects[1,2]...well tolerated by children.[1]

AFTER T & A, the gentle antifebrile-analgesic action of Tylenol reduces restlessness, aids recuperation.

TYLENOL ELIXIR—120 mg. (2 gr.) per 5 cc.; 4 and 12 fl. oz. bottles
TYLENOL DROPS—60 mg. (1 gr.) per 0.6 cc.; 15 cc. bottles with calibrated droppers

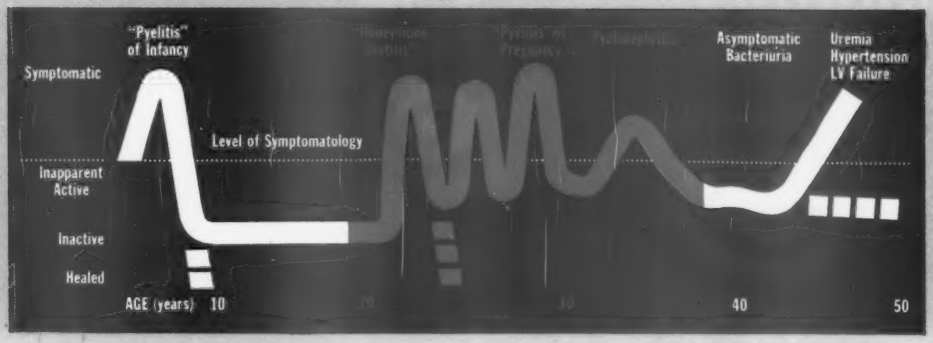
Also available for adults and older children:
Tablets TYLENOL—5 gr. (300 mg.)

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.

1. Cornely, D. A., and Ritter, J. A.: N-acetyl-p-aminophenol (Tylenol Elixir) as a Pediatric Antipyretic-Analgesic, J.A.M.A. *160*:1219-1221 (April 7) 1956.
2. Mintz, A. A.: Management of the Febrile Child, J. Ky. Acad. Gen. Pract. *5*:26-31 (January) 1959.

Natural History of Pyelonephritis



"... the theme that runs through the carefully taken history of most uremic patients with chronic pyelonephritis—the burning on urination of infancy, the chills and fever in childhood, the 'honeymoon' pyelitis, the recurrent urethritis treated so well and often locally—and yet the termination in uremia."[1]

the child-bearing age—a second major stage for urinary tract infection

"The fact that the many cases of chronic and finally, lethal, upper urinary infections in women begin or recur during gestation is especially challenging."[2] "We now believe that all prepartum women should have one quantitative urine culture as part of their medical management."[3]

Furadantin—when pregnancy initiates (or activates) urinary tract infection

In a study of 104 pregnant women with urinary tract infections: "FURADANTIN was highly effective in the treatment of these infections during all stages . . . and frequently offers the best chance of effecting a clinical cure."[4]

FURADANTIN DOSAGE DURING PREGNANCY AND THE PUERPERIUM: The average dose is one 100 mg. tablet 4 times daily, given with meals and with food or milk on retiring, to prevent nausea. For acute, uncomplicated infections, 50 mg. q.i.d. may be administered. If improvement does not occur in 2 or 3 days, increase dosage to 100 mg. q.i.d.

SUPPLIED: Tablets, 50 mg. and 100 mg. Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Birchall, R.: Am. Practit. *11*:918, 1960. 2. Benson, R. C., and Mitchell, J. C.: Clin. Obstet. Gynec. *1*:97, 1958. 3. Favour, C. B.: Southern Med. J. *54*:848, 1961. 4. Nesbitt, R. E. L., Jr., and Young, J. E.: Obstet. Gynec. (N. Y.) *10*:89, 1957.

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EATON LABORATORIES, Division of The Norwich Pharmacal Company, NORWICH, NEW YORK

To cure or control infection throughout the urinary system at every age of life... at every stage of infection

Furadantin®

brand of nitrofurantoin

IRON PLUS THE BENEFITS OF A FECAL SOFTENER

OPTIMAL RELEASE IN THE AREA OF OPTIMAL UPTAKE

NEW FERRO-sequels®

SUSTAINED RELEASE IRON CAPSULES LEDERLE

A rational approach to the treatment of iron deficiency. The sustained, timed action releases the bulk of the iron in the duodenum-jejunum and some in the ileum, closely approximating the normal sequence of absorption of medicinal iron.[1] The possibility of G. I. irritation is reduced because ferrous fumarate is an improved, better tolerated iron, and concentration of iron is not unduly high at any point. FERRO-SEQUELS also contain dioctyl sodium sulfosuccinate which helps soften stools for easier elimination.

Each two-tone, green FERRO-SEQUELS contains:

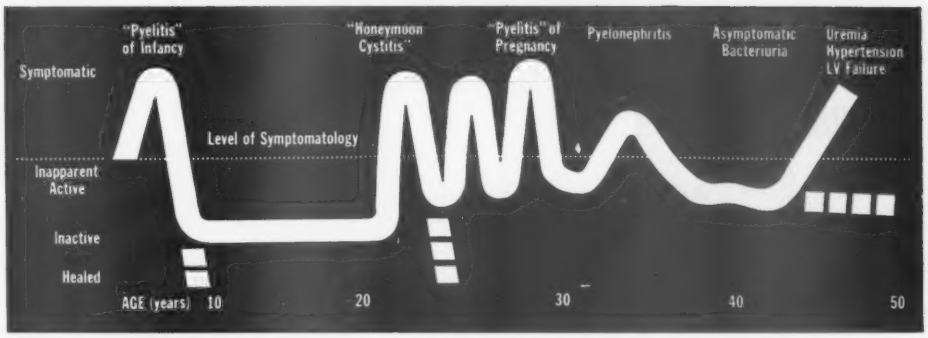
Ferrous fumarate (equivalent to 50 mg. elemental iron)	150 mg.
Dioctyl sodium sulfosuccinate	100 mg.

Dosage: 1 or 2 SEQUELS daily. Supplied: Bottle of 30.

1. Goodman, L. S., and Gilman, A.: The Pharmacologic Basis of Therapeutics, Second Edition, The Macmillan Company, New York, 1955, pp. 1454-5.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Natural History of Pyelonephritis



". . . the theme that runs through the carefully taken history of most uremic patients with chronic pyelonephritis—the burning on urination of infancy, the chills and fever in childhood, the 'honeymoon' pyelitis, the recurrent urethritis treated so well and often locally—and yet the termination in uremia."[1]

during the middle and later years—relapse, reinfection, renal failure

". . . the physician treating a patient with established chronic urinary tract infection faces a grave problem of management."[2]

Furadantin—to preserve function; to prolong life

". . . certain patients with renal insufficiency derived measurable benefit from prolonged nitrofurantoin treatment; as infection was suppressed their renal function improved. This effect was sufficiently pronounced to be considered an important component of the management of uremia accompanying chronic pyelonephritis."[2]

FURADANTIN DOSAGE IN LONG-TERM THERAPY: "With normal renal function, the dosage schedule of 50 mg. four times daily in adults gave urinary nitrofurantoin concentrations that usually exceeded 5 mg. per 100 mg. throughout the day. This level was thought to be sufficient, on the basis of bacterial sensitivity determinations."[3] In refractory cases, 100 mg. q.i.d. daily is recommended.

SUPPLIED: Tablets, 50 mg. and 100 mg. Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Birchall, R.: Am. Practit. *11*:918, 1960. 2. Jawetz, E., et al.: A.M.A. Arch. Intern. Med. *100*:549, 1957. 3. Lippman, R. W., et al.: J. Urol. *80*:77, 1958.

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To cure or control infection throughout the urinary system at every age of life... at every stage of infection

brand of nitrofurantoin

in the treatment of vaginitis... physicians have asked...

Q How do TRIB SUPPOSITORIES and CREAM differ from other antivaginitis agents?

A Only TRIB preparations contain Triburon Chloride, the wide-spectrum *topical* microbicide which is effective in trichomonal, monilial and bacterial infections.

Q Why is this important for vaginal therapy?

A Since vaginal infections are rarely caused by single invading organisms, the broad-spectrum effectiveness of TRIB agents assures greater healing in more patients.

Q What distinct advantages do TRIB preparations have over broad-spectrum antibiotics and other microbicides?

A Though TRIB is effective against most commonly encountered vaginitides, including many antibiotic-resistant staph. and strep., resistant strains rarely develop in spite of prolonged use. Since Triburon Chloride is used only topically, there is no danger of sensitizing the patient to an antimicrobial which the physician may wish to use systemically.

Q How do TRIB preparations penetrate the vaginal rugae which often harbor pathogens?

A TRIB preparations are water-soluble and self-emulsifying, assuring a high rate of diffusion and prolonged retention.

Q What other TRIB properties promote healing?

A TRIB preparations approximate the pH of the normal healthy vaginal tract and are not irritating to the mucosa. Also, their many esthetic features encourage patient cooperation, even in prolonged usage.

ROCHE LABORATORIES Division of Hoffmann-La Roche Inc.

Trib™ Vaginal Suppositories and Cream

contains Triburon® Chloride 0.1%

consistent response in vaginal infections

American Medical Women's Association, Inc.

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(Continued on Page 921)

American Medical Women's Association, Inc.

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(Continued from Page 920)

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(Continued on Page 928)

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- RAPID SYMPTOMATIC RELIEF: itching and burning usually disappear after only 1 or 2 TRIB applications.
- EFFECTIVE IN ALL THREE: trichomonal, monilial and nonspecific bacterial vaginitis respond to TRIB in up to 85% of cases.
- NONSENSITIZING, NONIRRITATING: no evidence of systemic or local reaction; TRIB is well tolerated in the vagina and on raw vulvar surfaces.
- DEMONSTRATED SAFETY: therapy with TRIB may safely be continued during pregnancy and menstruation without untoward reactions.

AND MOST IMPORTANT TO YOUR PATIENTS...

- ESTHETICALLY ACCEPTABLE: suppository and cream are smooth, white, odorless, nonstaining and can be conveniently administered with accompanying applicators.

Supplied: TRIB VAGINAL SUPPOSITORIES—Boxes of 24 with reusable applicator. TRIB VAGINAL CREAM—3-ounce tubes with 18 disposable applicators. Consult literature and dosage information, available on request, before prescribing.

TRIBURON® CHLORIDE—N,N'-bis[1-methyl-3-(2,2,6-trimethylcyclohexyl) propyl]-N,N'-dimethyl-1,6-hexanediamine bis (methochloride)

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Trib™ Vaginal Suppositories and Cream

contains Triburon® Chloride 0.1%

consistent response in vaginal infections

in Ob-Gyn practice: prevent bacterial insult to traumatized cervicovaginal tissue

FURACIN®

brand of nitrofurazone

a safe, single agent with singular benefits

From a recent study reporting the lowered incidence of postoperative morbidity following the use of FURACIN Vaginal Suppositories in operative gynecology—"Certainly a single agent is to be preferred to a combination of agents, providing comparable results are obtained."*

Used before and after cervicovaginal surgery, delivery, radiation therapy and certain office procedures, FURACIN controls infection, hastens healing, reduces discharge, malodor and discomfort.

FURACIN VAGINAL SUPPOSITORIES: FURACIN 0.3% in a water-miscible base. Box of 12, each 2 Gm. suppository hermetically sealed in yellow foil.

FURACIN CREAM: FURACIN 0.2% in a water-miscible cream base. Tube of 3 oz. with plastic plunger-type applicator.

*Grimes, H. G., and Geiger, C. J.: Am. J. Obst. & Gynec. 79:441, 1960.

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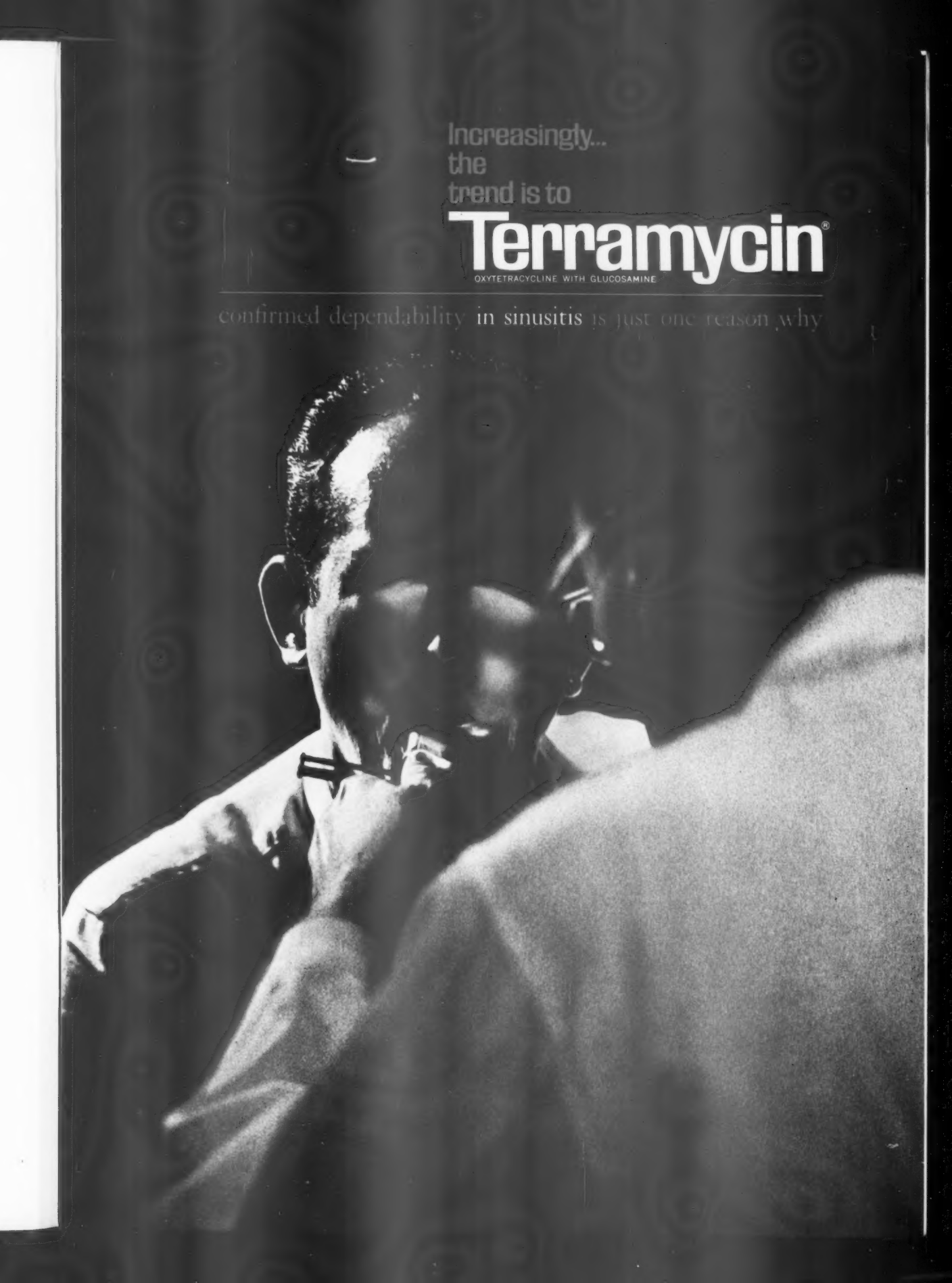
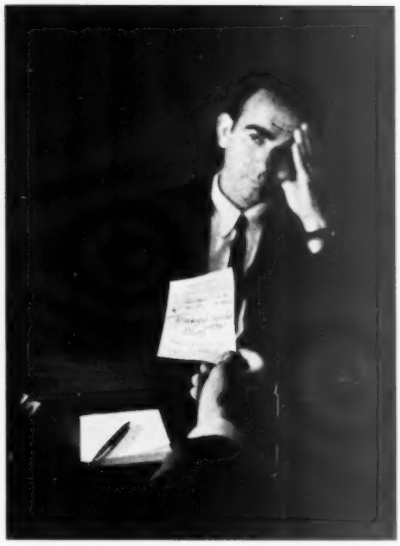
Division of The Norwich Pharmacal Company
NORWICH, NEW YORK


Increasingly...
the
trend is to
Terramycin®
OXYTETRACYCLINE WITH GLUCOSAMINE
confirmed dependability in sinusitis is just one reason why

According to a recent report* on the effectiveness of Terramycin in 106 cases of upper respiratory tract infection: "The response in sinusitis was particularly gratifying, as both acute and chronic cases were controlled within an average of five days."

"It was the impression of the hospital staff that oxytetracycline **[Terramycin]** was not only better tolerated, but more effective than other antibiotics habitually used."

The results reported in this and many other studies confirm the vitality of Terramycin for broad-spectrum antibiotic therapy and demonstrate why —increasingly—the trend is to Terramycin.



In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

More detailed professional information available on request.

Terramycin®

OXYTETRACYCLINE WITH GLUCOSAMINE

CAPSULES *250 mg. and 125 mg. per capsule*

convenient initial or maintenance therapy in adults and older children

another reason why the trend is to Terramycin—*versatility of dosage form:*

TERRAMYCIN Syrup/Pediatric Drops
125 mg. per tsp. and 5 mg. per drop (100 mg./cc.), respectively—deliciously fruit-flavored aqueous forms . . . preconstituted for ready oral administration

TERRAMYCIN Intramuscular Solution
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Science for the world's well-being® Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, N. Y.

*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

"but why don't you tell my patients...?"

We pharmaceutical manufacturers, over the past several years and in various ways, have been trying to tell the story of the drug industry's role as a member of the American health team, and thus to correct certain unfortunate misconceptions. And all along we have looked upon you of the medical profession, on whose good will we are so dependent, as perhaps our chief audience.

But now we wonder . . . because so many of you have said to us lately, either orally or in writing, "Why are you telling us this? Our patients are the ones who really need to hear this story."

Thank you for pointing out this need; and for the aid some of you have already given us. We think we can now be of still more help in answering many of the questions your patients are asking:—

A good number of us have Speakers Bureaus. If you will designate the place and time, we will have an industry speaker on hand to address any favorite organization of yours . . . be it a civic, political, or church group; your local PTA; a social club, or a fraternal order.

You have only to send a letter or post card, giving the particulars, to the Office of Public Information, Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C. (or phone, National 8-6435). They will make the necessary arrangements* (or promptly let you know if there's any hitch).

* But please try to give at least three weeks' notice.

"the pill"...

some timely comments

***Ovulation is inhibited during cyclic therapy with* ENOVID.** This single fact has made conception control by oral means a reality. As Guttmacher[1] states, oral therapy with ENOVID "is the best, the most effective contraceptive known to man. Its failure rate in patients who take it consistently is virtually zero."

Therefore, a physician's decision to prescribe ENOVID for conception control is likely to be influenced by considerations other than lack of faith in its *dependability*.

ENOVID is easy to take, economical and effective. But more important to the physician and the woman is the possibility of long-term undesirable effects.

Conception control by oral means deserves to be viewed with healthy scientific skepticism. "No method[2] of pregnancy spacing, even though highly effective, is justifiable if it endangers life or health." In the case of ENOVID, overwhelming evidence has been accumulated to establish not only its efficacy—but its *singular safety*.

The effects of ENOVID have now been studied in more than 3,500 women during more than 49,500 menstrual cycles, representing 3,800 woman-years of experience. ENOVID has been administered *cyclically* to the same patients for as long as five and one-half years for ovulation inhibition, and in other patients it has been administered *continuously* for more than a year in the treatment of endometriosis. *No true toxicity or contraindication to* ENOVID *therapy has been observed.*

There has been no impairment of subsequent fertility. ENOVID produced no masculinization or other harmful effect on the fetus when given to women who had already conceived. Although a cautious limit of two years is presently set for cyclic therapy with ENOVID, it is expected that this period will be lengthened as experience continues to accumulate.

ENOVID is available in tablets of 5 mg. and of 10 mg. Available on request: literature and references covering more than six years of intensive clinical study.

1. Guttmacher, A. F. (Chairman and Moderator): Clinical Experience with and Practical Techniques for the Use of Enovid in Ovulation Control, Transcript of a Closed Circuit Television Symposium, Chicago, G. D. Searle & Co., Jan. 18, 1961, pp. 26-28.

2. Cook, H. H.; Gamble, C. J., and Satterthwaite, A. P.: Oral Contraception by Norethynodrel. A 3 Year Field Study, Amer. J. Obstet. Gynec. *82*:437-445 (Aug.) 1961.

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ENOVID®

(brand of norethynodrel with 4-hydroxyanisole 3-methyl ether)

American Medical Women's Association, Inc.

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(Continued from Page 921)

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Meetings held each April, in conjunction with state medical meeting.

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President: Kathleen Weston, M.D., 261 Corne Rd., Ann Arbor, Mich.

Secretary: Lillian Diakow, M.D., 2343 Trenton Dr., Trenton, Mich.

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President: Elizabeth Stern, M.D., 4600 Gainsborough Ave., Los Angeles 27.

Secretary: Linda K. Morimoto, M.D., 317 East Second St., Los Angeles 12.

Membership Chairman: Edith Shepard, M.D., 1014 S. Spaulding, Los Angeles.

TWENTY-FOUR, KANSAS

President: Mary T. Glassen, M.D., Phillipsburg.

Secretary: Ruth P. Spiegel, M.D., Formosa.

Next meeting will be held on call.

TWENTY-FIVE, PHILADELPHIA, PENNSYLVANIA

President: Joan Buchanan, M.D., Glen Mills, Pa.

Secretary: Eleanor Roverud, M.D., Woman's Hospital, Preston and Parrish, Philadelphia 4.

Meetings held three times a year.

TWENTY-NINE, ATLANTA, GEORGIA

President: Marguerite L. Candler, M.D., 3092 Argonne Drive, N.W., Atlanta.

Secretary: Betty Ann Brooks, M.D., 720 Church St., Decatur, Ga.

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(Continued on Page 972)

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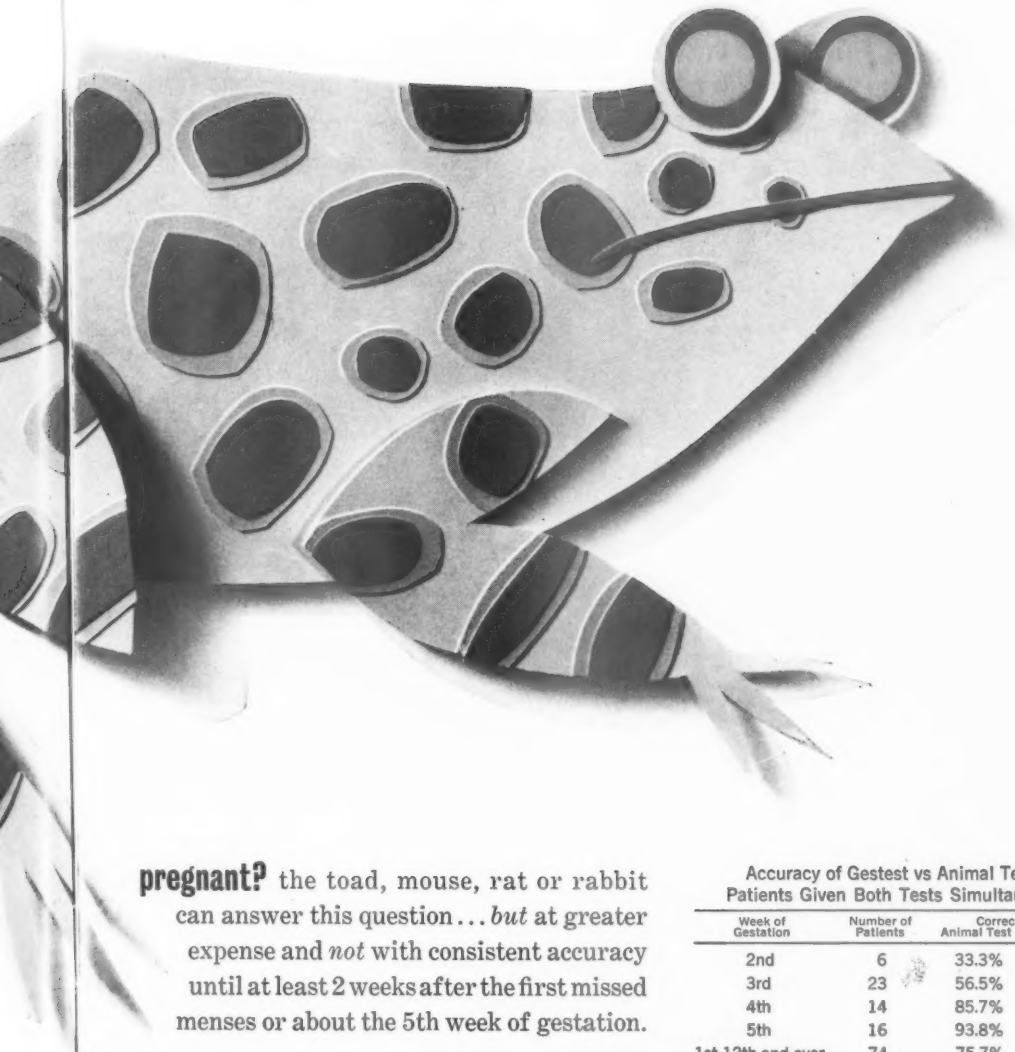

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4th	14	85.7%	100%
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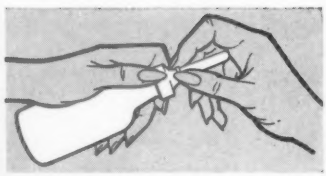

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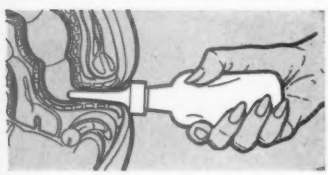
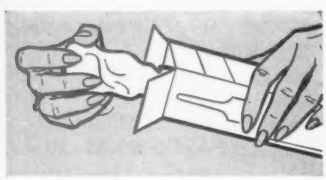


2. *Easy to administer*...just squeeze bottle with one hand...no contact with rectal area



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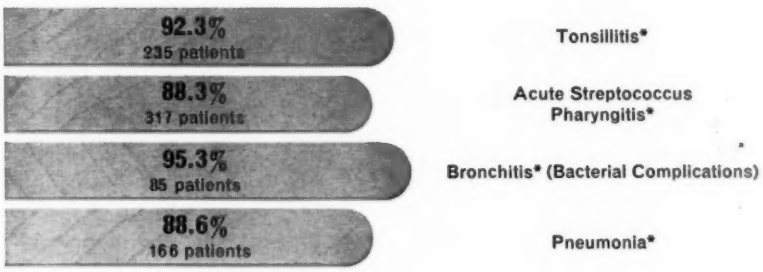

***References supplied on request.**

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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

Volume 16 December, 1961 Number 12

The Doctor's Dilemma — Updated*

Claire F. Ryder, M.D., M.P.H.

ANY COMMENCEMENT IS an inspiring occasion. The very word commencement has a vital, dynamic quality indicating the successful completion of one phase of life and the start of another.

Commencement day has a special significance for you as graduates from a school of medicine. This day marks the end of 20 years of formal schooling, much of it arduous and grueling. But of far greater importance is the fact that on this day you have taken the Hippocratic Oath and are formally launched on your careers in the medical profession.

As president of the American Medical Women's Association, may I extend a most hearty welcome to each of you from the medical profession and wish you long and fruitful years in the work of your choosing.

First, before getting into the topic of my address, I should like to reflect and review briefly with you some aspects of the changing status of women in the medical profession. On this special day, it is most fitting that we commemorate those determined and dedicated women physicians who worked to achieve the professional emancipation that women in the medical profession enjoy today. It is because of them that the "doctor's dilemma" I refer to is not for women only but for all physicians.

The contribution women have made to medical science can be traced far back in history. In 1228 B.C., the daughter of Aeetes, King of Colchis, practiced in her father's

*Commencement address delivered at the Woman's Medical College of Pennsylvania, Philadelphia, June 13, 1961.

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court, specializing in antidotes for poison. In addition to the fact that she was probably one of the first "hen medics," we might even claim that this early pioneer established the forerunner of our modern-day poison control center.

In 506 B.C. we find what may have been the first revolt by a woman against legislation forbidding women to study medicine. In defiance of such a ruling in Athens, Agnodice, a woman of noble birth, dressed herself as a man and was thus able to learn the healing art. She restricted her practice to female patients, revealing her secret only to them. So successful a practitioner did she become that public attention was focused on her work. Soon the truth about her identity became known and she was condemned to death. Her patients rallied to her defense, and their concerted protests not only saved her life but led to the passage of a new law permitting women to study medicine and to treat female patients.

Through the medieval period, women could study medicine in many universities, and many became professors. However, in the fifteenth century male physicians organized to block the progress of women in the medical profession. England led the way with the passage of a law forbidding women to practice medicine under threat of imprisonment. Opposition to women in the field of medicine increased, and other countries followed suit with similar laws.

The modern crusade to permit women to have a medical education had its start a little more than a century ago, when Elizabeth Blackwell succeeded in gaining acceptance to Geneva University (now Hobart) in New York. After graduation, she faced her next hurdle—overcoming united opposition on the part of the medical profession against allowing a woman to gain hospital experience. After numerous rejections from hospitals in this country, Elizabeth Blackwell went abroad and obtained clinical training in hospitals in France and England. Upon her return she once more had to fight for her rights—this time to practice medicine in her own community. Elizabeth Blackwell's consistent efforts and successful accomplishments not only triumphed for herself but made it possible for future generations of women to have the opportunity to receive medical education and training.

As women in the medical profession, we can look back with pride at the work of Marie Zakrezewska. A Polish noblewoman and former professor of midwifery in a medical school in Berlin, Dr. Zakrezewska obtained a medical degree in the United States and subsequently became our nation's first specialist in the practice of obstetrics.

Dr. Mary Edwards Walker paved the way to participation of women in military medicine. Until 1864, Dr. Walker served as a nurse in the Union Army and then was commissioned as Assistant Surgeon, the first woman so honored.

A most notable contemporary physician, Dr. Florence Sabin was the first of our sex to achieve numerous honors: the first to be made a full professor at Johns Hopkins Medical School, the first to be invited into membership in the Rockefeller Institute for Medical Research, and the first female member of the National Academy of Sciences. At the age of 67, she embarked on a new career, working in the field of public health in the State of Colorado. Two years ago, a bronze statue of Dr. Sabin was placed in Statuary Hall of the National Capitol, representing not only the achievements of women per se, but also as a tribute to the profession of medicine. As women physicians, we can bask in the reflected glory of this remarkable woman.

And, indeed, we all take pride in the appointment this past year of Dr. Janet Travell as personal physician to President Kennedy—a triumphant milestone signifying the changing status of women in the medical profession.

But now to turn to the real "doctor's dilemma" today. What will *your* role be as physicians in this rapidly changing world of ours? Let us first recognize that medicine today is different than it was a decade ago, and even more dramatically different than it was two decades ago, the year you first started your schooling.

The population explosion we are experiencing in the United States means that there are increasing numbers of persons to be served. But of even greater significance is the marked alteration in the age composition of our population, showing a sharp increase in the number of older persons. Unfortunately, the manpower and womanpower in the professions are not keeping pace with the steadily increasing need for services.

Currently there are over 16 million Americans who are 65 and older. A dramatic index of the sharp rise in the number of our senior citizens is the fact that this represents a 236

per cent increase over the number of older persons in our population just 40 years ago. To make a further comparison with the year 1920, life expectancy for a person born then was 54.1 years; life expectancy for the person born in 1959 (the latest year for which estimates are available) rose to 69.7 years.

As members of the medical profession, we can take justifiable pride in the fact that increasing numbers of Americans are living into the so-called golden years. Coupled with the notable advances in medical care that have taken place in recent years is our great success in the primary prevention of infectious diseases. Public health applications of medical research triumphs have drastically reduced, and in some cases eliminated, the great toll that these diseases used to take of infants and children.

Progress in preventive measures against infectious diseases has sparked what might be termed a revolution in disease, and has resulted in a significant shift to chronic ailments in the health profile of the American population. It now appears that for the privilege of living longer we have to pay in the coin of the degenerative diseases. Those prevented from dying of typhoid fever, smallpox, pneumonia, and other diseases with high mortality rates a generation ago are now living on to die of cardiovasular disease, cancer, diabetes, or some other chronic disease with high prevalence among older people.

National Health Survey data show that three fourths of all aged persons have one or more chronic conditions. In comparison with the rest of the population, the over-65 age group suffers two to three times as much from chronic illness. And although the aged represent less than 9 per cent of the population, they constitute over 55 per cent of all persons with limitations in mobility due to chronic illness.

These are the over-all dimensions of the doctor's dilemma. It is no exaggeration to say that the health and medical professions have found their tasks remade for them by the increasing number and proportion of older persons in the population. As physicians we must appreciate the effect of these changes on our clinical practice and research. Furthermore, since we are basically responsible for the increase in the aged population, we must do something about meeting the health needs of this group.

The challenge to the medical profession is magnified by the time lag that now exists between progress in research and application of findings at the grass roots level. Our government invests millions of dollars annually in medical research. Recent discoveries have given us the potential of substantially reducing deaths from cancer, preventing some heart diseases, reducing mental illness, lessening physical handicaps, saving eyesight, eradicating tuberculosis, preventing poliomyelitis, and drastically reducing the incidence of tooth decay. But the fact is that unnecessary deaths and handicaps continue to occur because vital break-throughs in research are not being applied at the grass roots level. I should like to cite a few examples of how this time lag adversely affects the health of our people.

I am sure you will recognize the first example as one to which our own Dr. Catherine Macfarlane has devoted so much of her time and energy. Cancer of the cervix can be detected in its earliest asymptomatic stage by an easy screening device—the Papanicolaou examination of cells. If all cervical cancers could be discovered in this way before they become invasive, it is predicted that cancer of this site would be 100 per cent curable. But the tragic fact is that more than 10,000 women die each year of cancer of the cervix. Other types of cancer are not so easily detected or controlled. Nevertheless, it is estimated that if all current knowledge of control, detection, and treatment of cancer were fully applied, at least 85,000 cancer deaths a year would be avoided.

Next to cataracts, the two leading causes of blindness are glaucoma and diabetes. Yet, about 1 million persons who have glaucoma and 1.5 million persons who have diabetes are receiving no treatment because they do not even know they have the disease! In countless thousands of these undetected cases, a simple screening test today followed by prompt diagnosis and treatment could prevent blindness in future years.

A great research triumph just a little over a decade ago was the demonstration that recurrent attacks of rheumatic fever can be prevented through continuous prophylaxis with antibiotics. But this knowledge—a vital tool against rheumatic heart disease—is still not applied generally. Currently, rheumatic fever and rheumatic heart diseases take 20,000 lives each year in this country. Illustrating the lack of application of this therapy are the findings of a recent study of 1,000 persons hospitalized because of recurrent attacks of rheumatic

fever. Ninety per cent of those affected—some 900 persons—could have avoided a second attack if they had been placed on a continuous schedule of antibiotics at the time of the first attack, and if they had conscientiously followed this regime.

Too often we tend to lose sight of the fact that a research discovery in the laboratory, until it is applied, saves mice not men. It is up to us, the members of the medical profession, to see that vital break-throughs in research do not break down at the delivery-of-services level.

Of course, the perfect solution to the problem of chronic illness would be total prevention. Hopefully, we look to the day when this will be a reality. But for the present, we must face up to the fact that we have no equivalent of Salk vaccine or smallpox inoculation for the degenerative diseases. However, despite the lack of definitive answers, it is a serious mistake to assume that nothing can be done with regard to primary prevention.

We would be remiss if we did not keep in mind the various guidelines provided by research. For example, we should give consideration to studies that would determine to what degree weight control is beneficial in heart disease and diabetes. We should be alert to research findings that suggest that the use of a fat-controlled diet and polyunsaturated fatty acid may be of value to some individuals as a means of lowering serum cholesterol. In these and many other research areas, sufficient evidence has accumulated to guide us in measures we can recommend for health maintenance.

Because of the great gaps in knowledge, reduction of the impact of chronic illness for the most part pertains not so much to the prevention of the occurrence of the disease as it does to the prevention of disabling after-effects. In this regard, our mightiest weapon is early detection—before complications have set in.

Screening for hidden disease has been successfully used as a casefinding tool for many of the serious disabling diseases: notably diabetes, glaucoma, tuberculosis, heart disease, cancer of the uterus, hypertension, and kidney disease. In those instances where tests indicate suspicious results, it is the prompt follow-through by the physician that makes the health-saving or even the life-saving difference.

How ironic that this valuable means of preventing so much unnecessary suffering is not fully utilized. How does one persuade the people to avail themselves of detection programs? Many chronic diseases have an insidious onset, with no obvious symptoms. When pain and discomfort compel the patient to seek medical attention, the disease, unfortunately, has already had a running start. This is but another aspect of the doctor's dilemma.

More than ever before, change is the keynote in medical practice, with the rate of change ever-increasing. In the past two decades the development of new diagnostic techniques, the discovery of new drugs that are dramatically effective in combating disease, and the change in the basic concept of the etiology and treatment of certain diseases have literally revolutionized the practice of medicine. Furthermore, it is not being overly optimistic to anticipate that additional breakthroughs will continue to make existing knowledge obsolete. All of these factors provide the backdrop to another dilemma of the modern physician—the need for continuous education and training.

You, the current medical school graduates, are in an enviable position, having had the opportunity to delve into some of the more recently introduced concepts of medical practice. And certainly these changes present a challenge to each medical school to keep its curriculum in tune with the times. But let us consider the effect of future change on you as the practicing physicians of tomorrow. A few years hence, when you are engaged in day-to-day activities, you will face the dilemma common to all physicians—how to find the time to keep abreast with medical progress. Find the time you must, for your effectiveness as physicians will be at stake. Increasingly, the application of new knowledge with regard to early detection or treatment of disease can spell the difference between life and death or between the limitation of functional impairment and extreme disability. And it goes without saying that you must possess the knowledge before you can apply it.

Many conscientious physicians make a concerted effort to keep up with current progress on a do-it-yourself basis. This is a step in the right direction, but even more effective is attendance at intensive refresher courses, workshops, or institutes, particularly with regard to restorative services for the chronically ill. To put it bluntly, graduation from medical school can no longer be considered the pinnacle of learning, but instead

must be regarded as a foundation on which to build. In other words, to function at maximum efficiency the modern physician must be a perpetual student.

But let me add a note of cheer—push-button progress may one day ease the lot of the physician in an unexpected manner. The British now manufacture a slide rule on which the physician records the patient's symptoms; once set in this way, the slide rule reveals a list of possible diagnoses for the consideration of the physician. Development of an elaboration of the diagnostic slide rule has been predicted. This would be a machine into which the physician would feed information gained from the bedside findings. A push of a button and a perfect diagnosis and therapy regime would emerge. Although this machine has yet to be invented, perhaps we should not be too skeptical. After all, the idea of man reaching outer space was once completely in the bailiwick of Buck Rogers. And think of what the doctor's dilemma of tomorrow may be!

But back to the realities of the present. In discussing the changes which have taken place, I have alluded to new concepts on medical care. In this regard, we have done a complete about-face with respect to our ideas on immobilization, particularly in therapy for chronic illness, which is usually associated with protracted confinement to bed. Formerly, attention was focused only on the treatment of the disease. However, what once was considered a therapeutic measure—bedrest—has boomeranged. We now know that immobilization will produce irreversible impairments more damaging than the disease itself. Immobilization has led to atrophy of muscles, contractures, stiffness and soreness of joints, incontinence, bedsores, and metabolic as well as psychologic changes.

It is most pertinent at this point to pass along a maxim dating back to 42 B.C. According to the ancient sage Publius Syrus: *Graviora quaedam sunt remedia periculis*. "There are some remedies worse than the disease."

The findings on the adverse effects of immobilization do not reflect upon the skills and effectiveness of physician services involved. What they do point up is the need for comprehensive care, including those many services needed to supplement and support physician care. This is at the core of the doctor's dilemma—updated: the need to integrate his services with the many ancillary paramedical services required in the treatment of the chronically ill.

Another aspect of today's dilemma is that dependency is no longer regarded as a measure of economic status only. As physicians we have become aware of the effect of physical, social, and emotional dependency upon the health of the individual. We have ample evidence of the extent to which dependency in one category tends to encourage dependency in other categories; and conversely, we have been encouraged by cases that clearly demonstrate that the achievement of independence in one sphere paves the way to independence in other spheres.

The shift to chronic ailments in the health profile of the American population means that the modern physician will be increasingly involved in measures to eliminate or minimize dependency through restorative medical services. Where older individuals are involved, we must lower our rehabilitation goals to make them more reasonable and practical than they are at the present time. Rehabilitation to make the individual physically capable for re-employment is an admirable goal, but not very feasible for the majority of older persons. However, we must keep in mind that responsibility in medical care includes the development of the maximum potential of the individual. When we rehabilitate the elderly, bedfast individual to the point of independent living—even if this can be only to permit him to care for his own personal needs—we restore to him a large measure of human dignity and self-respect.

A few decades ago the practice of medicine was relatively uncomplicated, consisting of a direct and close patient-physician relationship with little or no involvement of ancillary personnel. Today, medicine is multifaceted and complex, and the changing role of the physician stems from the technological advances in medicine, the growing trend to specialization, the role of clinics, and the tendency toward combined practice.

To meet the complicated needs of long-term patients, the physician can no longer serve as a self-sufficient entity. He must have the help of paramedical personnel: nurses to serve in the home, physical therapists, speech therapists, social workers, homemakers, and others. Moreover, the modern physician now finds that he must call upon community resources to provide the essential supportive services and personnel. To an increasing ex-

tent, the physician must become a counselor to his patients, serving as liaison between them and community resources.

For the old-time family physician who has devoted a lifetime of practice based on a close doctor-patient relationship and sole management of his patient, comprehensive medical care calls for a breaking away from the traditional approach. Now he must supervise and consult with nurses, therapists, and medical specialists. However, such shared responsibility should in no way detract from his basic relationship to the patient.

How well the practicing physician can function on a team depends to a large extent on the services and facilities available within the community. Many problems of integration and co-ordination of services must be resolved on the community level. Furthermore, the physician must be adaptable to working with the team in a variety of settings—the hospital, the nursing home, or the patient's own home.

In those communities in which the vital ancillary services are not available, the physician is obviously handicapped. In many communities, however, there exists not a dearth but a plethora of services with duplication and overlapping of some services, and lack of coverage in other vital areas. For example, in one community of 100,000 population, a recent survey showed that there were over 200 agencies, programs, and services provided for the chronically ill and older individuals.

Consider the dilemma of a physician in such a community when he attempts to find the answers he must have. Which agency can provide the services needed for his patient? If institutionalization is required, which is the proper facility? If social services are needed, where can the necessary resources be found? The physician in his search for the appropriate solution must often use—and indeed waste—much of his valuable time in making numerous calls or contacts.

In an effort to resolve this problem, an increasing number of communities are marshalling their resources, creating programs which enable agencies, facilities, and services to function in a combined or correlated action. This has taken many forms—ranging from the simple roster of resources to the creation of complex central information, referral, and counseling services. These measures are designed to assist the physician in his search for the appropriate, comprehensive, and continuous care needed by his patients.

It is thus clear that an updated version of the doctor's dilemma has many dimensions. First the practicing physician of today must become oriented to the changing population pattern and the corresponding changes in medical needs. In a real sense, he must also be a perpetual student in order to keep up with the constant advances in medical technology. Then, modern physicians should become acclimated to the team approach, working with others in the health and social welfare fields. And, finally, the physician has a responsibility to participate in the development and operation of essential health services within the community.

As researchers uncover new knowledge and develop new techniques for the primary or secondary prevention of chronic diseases, the physician must use his talents in the public health effort to translate these findings into action programs. In this regard, Thomas Huxley's comment is most pertinent: "Knowledge is meaningless unless it leads to action."

This, then, is medicine today. A dilemma, true, and one that is challenging, demanding, complex—and wonderful. Now indeed is an exciting time to start.

Many Women Physicians Combine Marriage and Medicine

Despite a rather common belief that many women physicians withdraw from medicine to raise families, Dr. Marion Fay, President of Woman's Medical College of Pennsylvania, Philadelphia, says 90 per cent of the graduates stay in practice. Ten members of WMC's 1961 class are married and 4 are mothers.

Placebo-Controlled Study with Phenformin (DBI) in Diabetic Children

Bessie Dituri, M.D., and H. David Mosier, M.D.

USE OF ORAL HYPOGLYCEMIC agents has justifiably aroused interest in those concerned with the management of juvenile diabetes.

Aryl-sulfonylureas, the first group of oral hypoglycemic compounds, were found to be ineffective in juvenile diabetics early in clinical trial.[1,2] The mechanism of this inadequacy appears to be related to their mode of action. This is largely, if not entirely, via stimulation of endogenous insulin secretion.[3] Since juvenile diabetes is theoretically characterized by a progressively decreasing mass of insulin-producing beta cells of the pancreatic Islets of Langerhans, some source of exogenous insulin would appear to be necessary. A state of complete insulin lack sooner or later occurred in youngsters given aryl-sulfonylureas. This was manifested by rapid deterioration of the individual into polyuria, polydipsia, weight loss, ketoacidosis, and coma.

Somewhat more recently a different class of compounds, guanidine derivatives, have been found to possess hypoglycemic properties. These properties are apparently mediated by inhibition of certain oxidative enzymes with increase of anaerobic glycolysis; the compounds are without known effect on endogenous insulin production.[4] The least toxic of these compounds in terms of gastrointestinal side effects is the hydrochloride of N' beta-phenethylformamidenyliminourea, phenformin, referred to hereafter as DBI.*

A growing group of somewhat conflicting reports regarding use of this agent in managing juvenile diabetes prompted this placebo-controlled long-term trial.

Since standards of so-called "control" and patient-physician concepts regarding the many possible facets of management vary widely, the prime factors compared are quantitative measures of glucosuria done at two to three month intervals, summaries of daily patient-determined qualitative tests of glucosuria (Clinitest), daily insulin requirement, and physical growth as plotted on the Wetzel grid.

A six to eight months placebo trial has been compared to an equivalent time period of DBI administration. A double-blind approach, though theoretically preferable, was considered to be potentially harmful and possibly unrewarding since proper patient care might on occasion necessitate breaking the blind. Insulin was taken regularly by all subjects during the entire course of this study. Family-patient co-operation varied from excellent to fair in this group of subjects. None of the very un-co-operative patients has been included in this report.

Nine patients were studied, four from the pediatric outpatient clinic of the University of California at Los Angeles, and five from the private practice of one of the authors. Another three patients were dropped from the study due to consistent admission of failure to take the medication because of dislike for taking pills, forgetfulness, and so forth.

The results of this trial are summarized in table I. Here it may be noted that the duration of diabetes mellitus in these patients

Dr. Dituri is Clinical Assistant Professor of Pediatrics, University of California at Los Angeles School of Medicine, and Head of the Pediatric Diabetic Clinic, Division of Pediatric Endocrinology and Metabolism.

Dr. Mosier is Associate Professor of Pediatrics, University of California at Los Angeles School of Medicine, and Head of the Division of Pediatric Endocrinology and Metabolism.

*We express our gratitude to the U.S. Vitamin Corporation for supplying DBI and placebo tablets.

TABLE I
Measurable Observations of Study

Patient	Age in Yrs.	Sex	Duration of Diabetes at Beginning of Study	Maximum Daily Dose of DBI	Average (Arithmetic) of Total Daily Insulin Dose		Average of 2 or 3 24-Hour Quantitative Urine Glucose Determinations on Each Regimen	
					DBI	Placebo	DBI	Placebo
G.P.	7	M	15 mo.	50 mg.	21 U	20 U	10 gm.	12 gm.
G.S.	15	M	3 yrs.	100 mg.	61 U	61 U	30 gm.	30 gm.
C.G.	7	F	2 yr.	50 mg.	18 U	20 U	10 gm.	8.5 gm.
L.S.	13	F	2 yr.	100 mg.	60 U	60 U	25 gm.	22 gm.
A.P.	4	F	12 mo.	50 mg.	16 U	15 U	9 gm.	10 gm.
G.L.	4	M	8 mo.	25 mg.	10 U	10 U	9 gm.	8.5 gm.
M.O'D	15	F	8 mo.	125 mg.	30 U	25 U	22 gm.	20 gm.
B.B.	5	M	7 mo.	50 mg.	12 U	12 U	12.5 gm.	15 gm.
A.W.	4	F	3 mo.	50 mg.	14 U	14 U	5.0 gm.	5.5 gm.

varies from three months to three years. Comparisons of quantitative urine glucose determination between DBI regimen and placebo regimen consist of an arithmetical average of two or three determinations each. Figure 1 is a comparison of Insulin dosage used while on DBI (black bars) with Insulin used while on placebo (white bars). The maximum daily dose of DBI ranged from 25 to 125 mg. Initial dosage for all was 25 mg. per day; this was increased at the rate of 25 mg. per day each week until the first complaint of nausea and/or vomiting, at which time the daily dose was decreased by 25 mg. and maintained at that level.

COMMENT

Our experience did not bear out a salutary effect on labile juvenile diabetes by DBI as

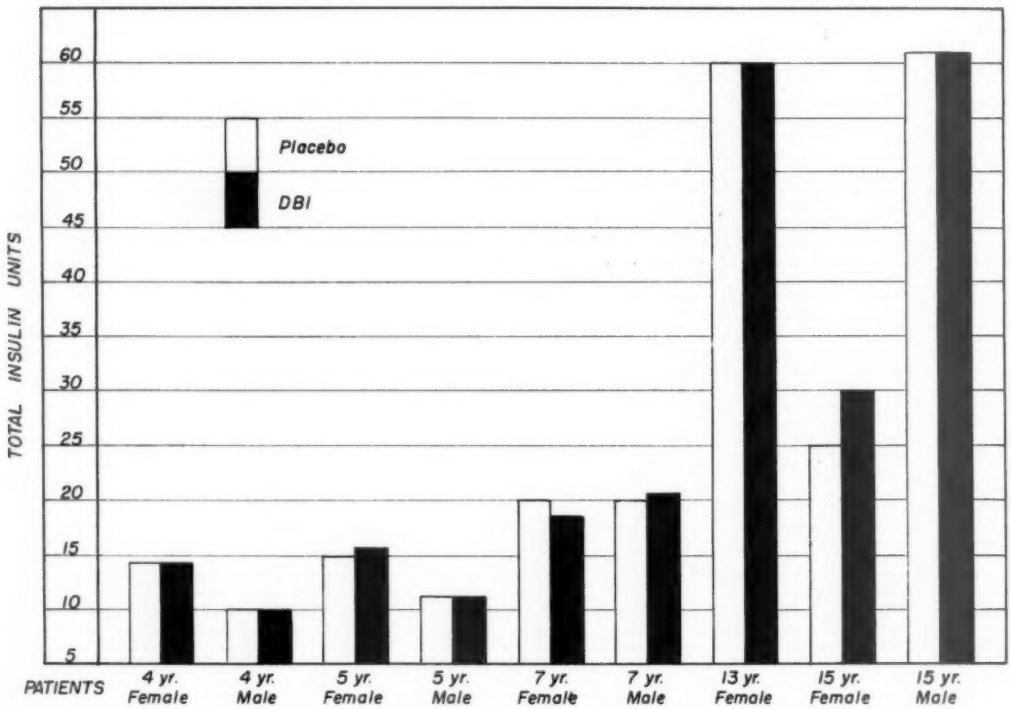

Fig. 1. Comparison of Insulin required by subjects while on DBI and placebo.

reported by some other workers.

There appeared to be no response to DBI which would justify significant lowering of Insulin dosage any more than there was to the placebo. No changes in growth curves were noted during the course of the study.

Considering the parallel of effective response between DBI and placebo in this study we question the wisdom of the use, in the growing age group, of an agent which has been shown to depress at least certain oxidative enzyme systems.[5]

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Membership Is My Business

As Executive Director, membership is indeed my business. Membership is the core of the Association without which the superstructure would soon disintegrate. Growing membership gave us courage to emerge from the confines of our cramped office space. Likewise our dreams of an expanding lectureship program, more loan scholarships, and more extensive international liaison can only be realized by the support of many members.

Our co-operation with other organizations expands as more members represent us, and as more funds become available to subsidize these efforts.

Medical recruitment, Junior Branch membership, and hospitality to the medical women on our hospital house staffs require the support and individual effort of many. From these projects come the members of the future and our assurance of the perpetuation of AMWA.

A larger membership gives to our annual meetings a wider choice of speakers, an expanding House of Delegates, and broader social contacts. From the nucleus of members in every branch, our leaders, the members of the Executive Board, are drawn; new service projects are sparked; and more helping hands can be outstretched to those coming up to join us in the ranks of medicine.

Membership is my business and I am willing to work at it. Are You?

—*Jessie Laird Brodie, M.D.*

Chronic Brucellosis: the Unreliability of Diagnostic Tests

Alice C. Evans, M.D. (Hon.), D.Sc. (Hon.)

THE VERDICT OF GUILTY of feigned illness unless proved innocent, or a diagnosis of neurosis, continues to be the common fate of patients suffering from chronic brucellosis. It is the purpose of this communication to point out that the evidence on which the damaging judgments are made is faulty. Because of the large number of patients involved in one sweeping indictment, the unreliability of the evidence is more obvious than ever before in the recent reports on 16 cases by Trever, Cluff, Imboden, and others.[1-3] The patients were Government employees in the bacteriological laboratory at Fort Detrick, Md., where studies on *Brucella melitensis* and *Br. suis* were in progress. Altogether 60 employees contracted brucellosis between 1945 and 1957. In a follow-up study made on 24 patients in whom the infection had been contracted four to eight years previously, it was found that in 16 patients the disease was prolonged for one to eight years. The authors state that they classified as having chronic brucellosis "all patients with complaints of malaise, fatigue, myalgia, arthralgia, backache, or feverishness for a period of one year or longer beyond the acute illness, unassociated with bacteremia, changing serological titer, on physical abnormalities."[3]

Miss Evans was formerly Senior Bacteriologist, National Institutes of Health, Bethesda, Md. She holds the honorary degrees of M.D. (Woman's Medical College of Pennsylvania) and D.Sc. (University of Wisconsin).

To account for complaints of ill health without detectable signs of disease the authors assume that their diagnostic techniques were adequate. Therefore, the complaints had to be ascribed to traits of personality. They "speculate that the reputation of brucellosis as a chronic disease supports the patient's tendency to retain his symptoms for long periods of time."[2] They further state that the results of their study led them to conclude that emotional disturbance that was more critically related to the personality prior to illness, than to the stress of the illness is the essential component of the syndrome.

By accusing the entire group, the reputations of the 16 individual patients were impaired. Possibly some of them were malingerers; others may have had psychoneurotic tendencies prior to infection. But these possibilities do not justify the blanket indictment of all the patients, for before their infection this group formed a cross section of the general population in respect to stability of character and neurotic tendencies.

In drawing their conclusions the physicians who studied chronic brucellosis in the patients of Fort Detrick apparently were influenced by the point of view of Spink, who is recognized as an authority on human brucellosis. He reported on a study of the chronic disease in Minnesota[4] where the infecting organism was predominantly *Br. abortus*. Among 65 patients who had not been treated with antibiotics, Spink found that 13 had prolonged illness for more than one year without demonstrable evidence of active disease. Six of the 13 patients were farmers or others who handled cattle in their daily work. The re-

maining seven were laborers in meat-packing plants.

Spink and his staff found it difficult to determine whether these chronic patients were suffering from active disease or from functional disorders. The classification of the 13 patients was as follows: In two individuals the state of their health was considered to be intimately related to the outcome of claims for compensation; four of the patients were of stable character and it was difficult to explain their ill health; seven were so maladjusted emotionally that diagnoses of severe psychoneurosis or psychopathic personality were made. Some of the individuals had clear-cut emotional problems prior to the onset of brucellosis, whereas in others the disease appeared to provoke emotional instability.

In "The Nature of Brucellosis" Spink[5] points out the possible causes of chronic illness in patients who fail to show objective signs of disease. He states that the intracellular form of parasitism, known for many years before it was confirmed in his laboratory, might explain the chronic clinical course and frequent exacerbations occurring in some patients. More recent experiments in his laboratory[6] emphasized that latent infections can persist over long periods, even after suppressive therapy.

Confirming Roger and Poursines[7] and others who found that in some cases of acute brucellosis the central or peripheral nervous system involvement may dominate the clinical picture, Spink[5] states that brucellosis has a "severe impact" on the nervous system, both central and autonomic. He thinks that this may be the most significant feature of the disease. He quotes Apter and co-workers[8] and Reitan[9] who found evidence of organic damage to the cerebral cortex in patients having chronic brucellosis.

Spink quotes Janbon and Bertrand[10] and also Castaneda,[11] who believe that the persistence of viable *Brucella* after the appearance of hypersensitivity plays a major part in the prolonged illness. Spink comments on the extreme degree of hypersensitivity to brucellar antigens exhibited by many of his patients.

Thus Spink, the medical scientist, summarized the information to be found in the literature and added to it the information gained in his laboratory, pointing out several approaches that may be taken in investigations of the chronic disease. But Dr. Spink, the physician, is annoyed by the patients who are always complaining without showing satisfactory evidence of disease. Repeatedly he has expressed his exasperation: "These tense and neurotic patients use brucellosis as a crutch."[12] "For the most part brucellosis is an occupational disease and the interpretation of chronic illness can be the result of disability insurance."[13] In making this remark Dr. Spink overlooked the fact that chronic brucellosis was as much a problem before as after disability insurance became available. Many years before brucellosis became compensable as an occupational hazard, I had discussed the chronic form of the disease.[14] Then, as now, the chronic phase followed the acute disease in many cases.

In the afore-mentioned quotation Spink[13] emphasized malingering as an explanation for prolonged illness following an attack of acute brucellosis, thus distorting the findings of his own study[4] in which he reported that 2 of a group of 13 patients with chronic brucellosis, who showed no objective evidence of disease, were malingerers. He recommended[13] that patients with acute brucellosis be told that theirs is a "self-limited disease," again apparently disregarding the results of his own as well as others' investigations, for he reported earlier[1] that in a follow-up study of a group of 65 of his formerly hospitalized patients, 46 per cent of them were found to have developed chronic brucellosis, their ill health having persisted for more than one year. Although he admitted that it would be a grave error to subject a patient with undetected active brucellosis to psychotherapy, he failed to state clearly that a mild, prolonged, localized infection, undetectable by diagnostic methods in present use, may nevertheless be the cause of neurotic symptoms charcteristic of the chronic disease. This article[13] has been severely criticized.[15]

Belief in the unreliability of negative results of tests now used to diagnose brucellosis is supported by Sir Weldon Dalrymple-Champneys, a member of the Ministry of Health, London, who began his study of brucellosis in 1928. His book[16] is based on his first 1,500 cases, excluding laboratory infections. He states that in cases in which brucellar infection persists for a long time, it may give rise to, or at any rate intensify, a neurosis. Blood culture and serum agglutination tests may be negative for a long time but they may finally establish the diagnosis. In cases in which the tests give negative results, Sir

Weldon believes that the nonfulfilment of the criteria should not exclude a diagnosis of brucellosis.

Most authorities on brucellosis[10,11,16-18] agree that clinical manifestations are unreliable for diagnosis. In many cases of the acute disease the clinical signs are not sufficiently characteristic to be useful; in the mild chronic disease the varying symptomatology is neither peculiar nor constant. Hence the diagnosis is made on the basis of laboratory tests.

Culture of *Brucella* from blood or tissue is considered to be the only proof of infection. But in many suspected cases, particularly in chronic cases, repeated attempts to obtain a culture give negative results. In such cases agglutination of brucellar antigen by the blood serum in significant titer is accepted as satisfactory evidence of infection. The titer considered significant varies with different investigators, most requiring at least 1:80 as the minimum, others requiring a titer as high as 1:200 for positive interpretation. These various empirical standards raise doubts as to validity because the titer of agglutinins varies greatly at different times in a given case, and it varies exceedingly from case to case, rising to 1:10,000 or higher in a few. If a titer of 1:80 is considered to be evidence of infection, a lower titer should at least suggest infection. In fact, as pointed out further on, titers lower than those accepted as indicative of infection are found commonly in chronic cases.

Most authorities[10,11,16-18] agree that due to the failure of both laboratory tests in some cases of infection the correct diagnosis is sometimes missed. This conclusion is based on the work of many investigators whose reports are listed in extensive bibliographies. To be brief, only two of these reports will be cited here.

Taylor and co-workers[19] found that 31.9 per cent of their 1,412 patients who were proved to be infected by positive hemoculture, showed no serum agglutinins in titers of 1:80 or higher. In most of these cases the reaction was positive in dilutions of 1:40 or lower, but in a few of them the results were completely negative.

Schirger and co-workers,[20] who studied 224 patients at the Mayo Clinic, Rochester, Minn., failed to obtain cultures in about 60 per cent of cases in which the diagnosis was confirmed by a significant titer of brucellar agglutinins. In 42 patients with chronic localized infection proved by culture of *Brucella* from specimens taken for biopsy or aspirations of specific tissues, the agglutinin titer was generally low, not exceeding 1:200 in most instances. In six cases it was absent. As a rule these chronic cases of localized brucellosis were not associated with a marked systemic reaction. In some instances no distinct physical findings could be attributed to the organ that was proved by culture to be infected.

In the study of most human infectious diseases, an indication of how the disease may affect man is obtained through animal experimentation. In the study of human brucellosis, more accurate information than could be obtained through experimentation comes from observations of the natural disease in domestic animals. Farmers dread brucellosis in their herds because they know that an infected animal may never again be profitable. The practical problem is stated concisely in a report by a Special Committee of the United States Livestock Sanitary Association:[21] "Many animals discontinue showing active symptoms but are still diseased. . . ."

Because the death rate of brucellosis is low, its tendency to incapacitate man and domestic animals for a long time must have been the feature that led to the choice of this disease as one to be investigated for its possible use in germ warfare. Nevertheless aspersions were cast on the patients of Fort Detrick because their illness was prolonged.

In a previous publication[22] I discussed the almost intolerable situation of patients suffering from chronic brucellosis who live for years under the shadow of a diagnosis of "neurasthenia," which vaguely implies malingering. The patients of Fort Detrick are highly vulnerable to the accusation of feigned illness, as are all patients who are eligible to disability compensation and/or medical care if their illness is a result of infection in line of duty. They will be treated as imposters if they are believed to be simulating illness.

The need for more accurate methods to detect chronic brucellosis is evident. Until techniques have been perfected, it would be in better accordance with accepted standards of justice to consider the patient innocent unless he is proved to be guilty.

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IBM Is Matchmaker for Medics

An IBM machine is being used to place interns in hospitals under a system that had its beginning nine years ago under the auspices of the American Association of Medical Colleges. In this system senior students state on a card their choices of hospitals in order of preference, and the administrators of the hospitals from a study of the students' qualifications state on the cards their preferences among the applicants. The cards are then fed through the machine and the preferences are matched. It is estimated that 95 per cent of interns in this country are placed in this manner.

Correction

In the June, 1961, issue of the Journal, there is an error in the article, "Residual Ovaries," by Dr. Grace T. Newman. On page 454 the statement should read: "In 63 per cent of my patients enlarged ovaries occurred within five years after the operation for hysterectomy."

EDITORIAL

Chronic Brucellosis

On page 942 of THE JOURNAL is an article on Chronic Brucellosis: the Unreliability of Diagnostic Tests, by Miss Alice C. Evans.

Miss Evans' interest in brucellosis developed when she was a research bacteriologist in the Dairy Division, U. S. Department of Agriculture. She had been directed to study the bacteria of cow's milk which come from the interior of the udder. The germ of contagious abortion proved to be the most interesting species of the varied flora, and she concentrated her studies on it. Her first paper on the subject was published in 1918. In it she pointed out the close relationship between the organism of bovine contagious abortion and that of human "undulant fever," and she suggested the possibility that the former might be the cause of human disease of unknown origin in areas where there were no goats.

Then came World War I and she was transferred to the Hygienic Laboratory (now the National Institutes of Health) to join a team working on a war problem—cerebrospinal meningitis.

In 1922 the first case of human brucellosis not traceable to goats was discovered in Baltimore. It was the event for which Miss Evans was waiting, and she returned to the brucellosis problem. We quote from "Brucellosis in the United States" (Am. J. Pub. Health *37:* 148, 1947) an account of the next incident, which gave her excellent opportunity to observe the chronic disease: "In October, 1922, the writer became infected while working on cultures of *Brucella melitensis* received from Phoenix, Ariz. For the first nine months the disease was mild. Medical aid was sought, and after examinations failed to reveal cause for complaint a diagnosis of 'neurasthenia' was received. Then came an acute exacerbation of typical 'undulant fever,' so diagnosed when a culture of brucellae was obtained from the blood. Then five years of poor health, with complete incapacitation much of the time. Again, medical aid was sought in four successive hospitals. The outcome was always the same; the patient was regarded as 'neurasthenic.' Finally the impasse was broken by the intervention of another disease which necessitated an operation during which brucellar lesions were found, from which *Br. melitensis* was cultivated. Thus accidentally, at last, came relief from the misunderstandings which inevitably must arise when a patient is said to be suffering from imaginary ills. These misunderstandings are a feature of chronic brucellosis that tries the patient almost beyond endurance."

Her infection resulted in a hypersensitivity to brucella organisms which prevented further handling of cultures, but her interest in brucellosis continued. In 1936-1937 she planned and co-ordinated an investigation of chronic brucellosis in three widely separated cities. In none of them was there an ordinance providing for the pasteurization of milk, although the cattle supplying the areas were known to be heavily infected with brucella organisms. A series of five papers reported this study, the last of which is perhaps the most interesting from the point of view of the physician (Chronic Brucellosis in Charlotte, N. C., by Robinson and Evans, J.A.M.A. *113:*201, 1939).

Dr. Robinson conducted a six month survey in a city of about 107,000 inhabitants. The search for cases of chronic brucellosis was made chiefly among patients suffering from chronic, unexplained ill health, particularly among those with long-continuing low-grade fever. Their exposure to brucella organisms was limited, generally, to the ingestion of milk and dairy products. Twenty-two patients were found, in whom chronic brucellosis appeared to be the logical diagnosis.

This account covers briefly the high points of Miss Evans' studies on brucellosis. It is published here with her permission.

President's Message

"He has half the deed done, who has made a beginning." These words of the ancient sage Horace come to mind as I ponder over the events which have taken place at AMWA during my term in office.

Since I took office a year and a half ago, far-reaching changes have been made in our constitution and by-laws, aimed at strengthening the basic structure of our organization. My heartfelt thanks go to the Board members and the office staff who gave unstintingly of their time and energies to accomplish the necessary groundwork for these changes. At times, I must admit, the responsibilities of the office weighed exceedingly heavy, particularly when policy making decisions were involved. On more than one occasion there was a longing for mystical powers, or at best a crystal ball, to bring forth the answers. Lacking these aids, we resorted to human judgment to arrive at solutions to our problems. Time will be the test of how well we judged, but we have made a beginning and we have implicit confidence that our new officers will follow through admirably.

The theme I had chosen for my term in office was "The Prevention and Control of Disability," which I viewed as the modern-day challenge to the medical profession. Since that time, increasing national attention has been focused on this problem area, culminating in the recent enactment by Congress of the Community Health Services and Facilities Act. This legislation is designed to provide Federal support for essential health services to meet the needs of the chronically ill and aged at the grass roots level.

Although this legislation represents an important milestone in meeting the health needs of a sizable segment of the American population, its effectiveness is dependent to a great extent on the support and leadership provided by the practicing physician. Certainly this is a matter of direct concern to all members of AMWA.

Another advance in the past year is the increasing utilization of electronics for diagnosis as well as therapy. To test whether a diagnostic computer can actually replace the flesh and blood physician, Dr. Keeve Brodman of the New York Hospital Cornell Medical Center gave various sets of symptoms taken from patients' questionnaires first to a computer, then to a physician. The results? When purely physical diseases were involved, the machine was more accurate than the physician. However, and this is most significant, as soon as the diagnoses involved psychosomatic symptoms, the importance of the human element came to the fore, and the physician was correct nearly twice as often as was the machine.

Thus, dramatic advances of technology as applied to medicine may supplement but not in any way replace the personal element in the practice of medicine. A stirring plea for greater personalization was recently made by Dr. T. F. Fox, Editor of *The Lancet*, when he said: "The independent doctor must work out a new role based less on the specialist techniques he learned in medical school and more on those that are necessary to his particular kind of practice. With a greater interest in preventive medicine, he should become, perhaps, more of a specialist in living. . . . An education truly based on science as it has latterly advanced would pay far more attention to the emotions of the patient."

To all of this I say a fervent "Amen." And I might add that here is an area in which women physicians are most adept, since the special aptitudes of women—patience, compassion, and intuitive understanding—equip them to make the best possible use of their medical training in dealing with the psychosomatic ailments as well as the complexities and discouragements of chronic illness.

I agree with Dr. Fox that the peronal aspects of medicine have been increasingly ignored. But we can see encouraging signs of the pendulum swinging back again. Tangible evidence of this trend is the topic chosen by our incoming President as the AMWA theme for the coming year, "Alcoholism."

Serving as the President of AMWA has been not only a great honor but a memorable experience that I shall always cherish. My heartiest congratulations and sincere wishes for success go to Dr. Brown and all of the other incoming officers. With this group at the helm, we can be confident that the AMWA will continue to grow in membership, in professional significance, and in service to the Nation.

Claire F. Ryder M.D. M.P.H.

Scholastic Awards—1961

Since 1953 the AMWA has honored the outstanding young women who graduated from medical school in top-ranking positions. This year there were 2 students graduating in first place and 15 who were in the upper 10 per cent of their class. These young women won honors in 11 of 84 U.S. coeducational medical schools; Woman's Medical College of Pennsylvania, Philadelphia, is the twelfth school represented. The following table illustrates the percentage of women graduating with honors from the 11 coeducational schools.

Percentage of Women Graduating from Eleven Coeducational Medical Schools with Honors

School	No. Graduating	Women Graduating		Women in Top 10%		
		No.	%	No.	% of Women Graduating	% of Total Graduating
N. Y. Med. College	120	6	5.0	1	16.7	0.8
Louisiana State U.	101	3	3.0	1	33.3	1.0
Baylor U.	86	4	4.6	1	25.0	1.2
U. of Buffalo	72	5	6.9	1	20.0	1.4
U. of Louisville	86	3	3.5	1	33.3	1.2
U. of Texas Med. Branch	103	5	4.9	2	40.0	1.9
U. of Kansas	96	2	2.1	1	50.0	1.0
U. Texas Southwestern	101	4	4.0	1	25.0	1.0
U. of Vermont	43	3	7.0	2	66.6	4.7
Ohio State U.	129	7	5.4	1	14.3	0.8
Med. College of S.C.	73	6	8.2	1	16.6	1.4
Totals	1,010	48	4.8	13	27.0	1.2

FIRST PLACE

JANE ANN AVERY FISCUS, M.D., graduated first in a class of 86 students from Baylor University College of Medicine, Houston. There were three other women in the class.

Dr. Fiscus and her husband, Dr. Wilbur Guy Fiscus, were two of the three Baylor medical students graduating this year "with High Honor."

Native of Wilburton, Okla., Dr. Fiscus earned her B.S. degree at Oklahoma State University.

Her nonmedical interests range from esthetics to athletics and include art, chess, and golf.

Dr. Fiscus is interning at Duke University Hospital, Durham, N.C.

ANTOINETTE C. RIPEPI, M.D., graduated in first place from the Woman's Medical College of Pennsylvania, Philadelphia. There were 39 students in the class.

From the time of her birth in Gallatin, Pa., until the present, Dr. Ripepi has lived, worked, and studied in Pennsylvania. High school studies in Monongahela were followed by enrollment and attendance at the University of Pittsburgh, where she was a member of the national biology society, Beta Beta Beta.

Practical experience was gained by Dr. Ripepi's spending three years as a medical

technician at the Montefiore School of Medical Technology in Pittsburgh before she entered WMC.

At medical school she was elected to membership in Alpha Omega Alpha. Now an intern at the Graduate Hospital of the University of Pennsylvania, Philadelphia, Dr. Ripepi has little time for hobbies of baseball, swimming, and badminton.

HONORABLE MENTION

LAUREL M. BARKER, M.D., graduated third in a class of 72 students from the University of Buffalo School of Medicine, Buffalo, N.Y.

Waitress, clerk, assembly-line worker, baby-sitter, secretary, swimming instructor, personnel supervisor, and sociological researcher are some of the jobs that Dr. Barker has held to enable her to begin, continue, and complete her academic education.

Even while studying for her B.A. degree at Connecticut College, Dr. Barker was self-

supporting. From the time of her graduation in 1950 until 1955, Dr. Barker worked steadily in New York City and Niagara Falls. Then, still working full time, she began to complete premedical requirements at the University of Buffalo night school. After another year and a half of steady work, she entered medical school.

A special ceremony was arranged for Dr. Barker at the Buffalo General Hospital, where she is interning. At that time she was presented with the AWMA citation.

SYLVIA ANN BARTOS, M.D., stood third in a class of 39 students graduating from Woman's Medical College of Pennsylvania in Philadelphia.

Dr. Bartos was born and raised in North Braddock, Pa. and attended schools there. After graduating from Scott High School she studied for a B.S. degree at Duquesne University in Pittsburgh.

Receiving high honors is not new to Dr. Bartos, as she graduated from Duquesne in 1957 *summa cum laude*.

Having left Pennsylvania for Chicago, Dr. Bartos is interning at the University of Illinois Research and Educational Hospital.

Her favorite sports are tennis and swimming.

BILLIE JO CAUDILL, M.S., M.D., graduated in the upper 10 per cent of her class from the University of Louisville School of Medicine in Kentucky. There were 86 students in the class.

As a child, Dr. Caudill moved with her family from Chicago to Murray, Ky., where she attended primary and secondary school and Murray State College.

There she received her B.S. degree "with distinction" in 1947. Since then, with interludes for graduate study and youth work, Dr. Caudill has taught biology, chemistry, anatomy, physiology, microbiology, and science at Campbellsville Junior and Moorehead State colleges in Kentucky and at the Richmond Professional Institute of the College of William and Mary in Virginia. Some summers she has worked for Dr. C. Louise Caudill, a general practitioner in Moorehead.

From 1949 to 1951 Dr. Caudill returned to student life, earning an M.S. degree from the University of Kentucky in Lexington;

her thesis was written on "The Desapoda and Amphipoda of a Typical Limestone Stream."

During her college days, Dr. Caudill was active in the Baptist Student Union. Since graduation, she has continued to work with the Union and other Baptist youth organizations. One year she was the director of the Union at Morehead, and more recently, while a medical student, she has worked for four summers at Baptist girls' camps.

Collecting antique ironstone china and gardening—"especially roses and tulips"—are two of Dr. Caudill's nonmedical interests. Others are photography, golf, books, and music.

Currently most interested in pediatrics, Dr. Caudill is interning at St. Joseph Hospital, Lexington.

Ann Rhaye Cook, M.A., M.D., graduated in the top ten per cent of her class from the University of Texas Medical Branch, Galveston. She was one of 5 women in a class of 103 students.

After earning her B.A. degree at the Rice Institute, Houston, Dr. Cook studied at the University of Texas Medical Branch, from which she received an M.A. degree in 1959.

Early in her career as a medical student, Dr. Cook was presented with the Freshman Chemistry Achievement award of the Chemical Rubber Publishing Company. Further indications of an outstanding record include Dr. Cook's election to membership in Alpha Omega Alpha and her selection this year as a participant in a special project, the Brookhave Project.

Currently interning at St. Joseph's Hospital in Fort Worth, Texas, Dr. Cook plans to become a general practitioner for a short time, after which she may specialize in internal medicine.

Jeannette L. DeAngelis, M.D., graduated in the upper ten per cent of her class from the New York Medical College, New York City. There were 6 women in the class of 120 students.

Dr. DeAngelis' home is in West Babylon, N.Y. She took her B.A. degree at Hunter College in New York City. Currently Dr. DeAngelis is working as an intern at New Rochelle Hospital in New York.

Kay Moore, M.D., graduated in the upper ten per cent of a class of 101 students from the Louisiana State University School of Medicine in Baton Rouge. She was one of 3 women in the class.

Having known that she wanted to become a physician "since I was 5 years old," Dr. Moore wasted no time in gaining her ob-

jective. She was less than 23 years old at the time she received her M.D. degree.

During her years as a B.S. candidate at Louisiana, Dr. Moore was a member of Phi Kappa Phi, Alpha Epsilon Delta, Alpha Lambda Delta, and German and chemistry fraternities.

As a medical student, she continued to hold membership in a variety of organizations: Phi Kappa Phi, the Undergraduate Surgical and Medical societies, and was elected to Alpha Omega Alpha.

Recipient of the Mosby Book award, Dr. Moore stood first in her class in her senior year.

Dr. Moore is now interning at the John Gaston Hospital in Memphis, Tenn.

"Cooking, especially desserts," is one of her favorite activities. She also enjoys reading.

TERUKO SHIMAMOTO NEUWALDER, M.D., graduated in the upper ten per cent of a class of 39 students from Woman's Medical College of Pennsylvania, Philadelphia.

A native of San Francisco, Dr. Neuwalder attended the High School of Commerce in New York City. After some years of study at Northwestern University in Evanston, Ill., she transferred to Antioch College, Yellow Springs, Ohio, where she was granted a B.A. degree in 1957. Before becoming a medical student she took additional studies at Columbia University, New York City.

Dr. Neuwalder is now interning at Philadelphia General Hospital. She and her husband, Dr. Herbert Franz Neuwalder, have a 14-month old daughter.

Piano-playing and golf occupy her spare time.

SUSAN MARY SANDSTROM, M.D., one of 5 women in a class of 103 students, graduated in the upper ten per cent of her class from the University of Texas Medical Branch, Galveston.

Dr. Sandstrom studied for a B.A. degree at the College of St. Catherine, in St. Paul, Minn.; she served as an extern at St. Paul's Hospital. Her hobbies of waterskiing and swimming were especially appropriate during these years in the "land of ten thousand lakes."

At the Medical Branch, Dr. Sandstrom was elected to membership in Alpha Omega Alpha. She is now an intern at Philadelphia General Hospital.

CAROL JEAN SCHALLER, M.D., graduated in second place from Woman's Medical College of Pennsylvania, Philadelphia. There were 39 students in her class.

Dr. Schaller, a native of Dubuque, Iowa, began her medical career as a nurse. She earned a B.S. degree in nursing at the University of Michigan, Ann Arbor, and worked full time as a nurse while completing her premedical studies at Temple University, Philadelphia.

As a senior at WMC she was elected to the vice-presidency of her class.

Dr. Schaller is now an intern at Bryn Mawr Hospital, Pa. In her spare time she likes to bowl and play golf.

CAROLE DEAN ROBERSON SIMMONS, M.D., graduated in second place from the University of Texas Southwestern Medical School, in Dallas. She was one of 4 women in a class of 101 students.

Born in Lubbock, Texas, Miss Roberson attended Texas Technological College there. While she was a premedical student she married Doyle Lee Simmons, and the couple entered medical school together.

During her senior year Mrs. Simmons took time off to give birth to her first child, a son.

Missionary work was at one time considered as a career by the couple. They are now more interested in the field of public health, and Dr. Carole is interning at the U.S. Public Health Service Hospital in New Orleans. Both she and her husband have spent two summers as externs in mental hospitals.

LADENE CUMMINS TERRY, M.D., graduated in the upper ten per cent of her class from the University of Kansas School of Medicine, Kansas City. She was one of two women in a class of 96 students.

After graduating from high school in her home town of Hollywood, Kan., Miss Cummins married the class valedictorian and became Mrs. Terry.

At the University of Kansas, Mrs. Terry received the Residence Hall Scholarship and was placed on the Dean's Honor Roll. She also belonged to Gamma Delta, a Lutheran students' society.

Dr. Terry is now interning at Iowa Methodist Hospital in Des Moines.

MARIANNE VAS, M.D., graduated in the upper ten per cent of her class from the University of Vermont College of Medicine, Burlington. In the class there were 43 students, of whom 3 were women.

Dr. Vas was born in Budapest, Hungary, where she graduated from high school and completed two years of the six-year program of medical study at the University of Budapest. After the Hungarian revolution in 1956 she came to the United States and continued her medical studies at the University of Vermont. In her senior year she was elected to Alpha Omega Alpha.

At present, Dr. Vas is interning at the Long Island Jewish Hospital in New Hyde Park, N.Y.

MARGARET MILES WADDINGTON, M.D., graduated in the top ten per cent of her class from the College of Medicine of the University of Vermont, Burlington. She was one of 3 women in a class of 43 students.

Dr. Waddington had her early education in Austria and France, and came to the United States in 1946. She completed her high school education in Port Washington, N.Y. Three years later—one at Finch Junior College, New York City, two at St. Johns University College in Brooklyn, N.Y.—she was granted a B.S. degree *cum laude*.

A dairy farm in Vermont occupied Dr. Waddington's attention for the next 7 years. She was partner and manager of a 250-acre dairy farm in Grand Isle County, and won the County's Soil Conservation award in 1954.

Dr. Waddington enjoys literature and conversation in five languages—English, German, French, Spanish, and Russian—and devotes time to a wide range of other nonmedical interests: carving, painting, water sports, skiing, and ping-pong.

She is interning at the Rhode Island Hospital in Providence.

GRETCHEN ANN WAGNER, M.D., formerly president of the local Junior Branch of the AMWA, graduated in the top ten per cent of the class from The Ohio State University College of Medicine, Columbus. There were 7 women in her class of 129 students.

Just two weeks after graduation, Dr. Wagner married a fellow-graduate and became Mrs. Charles Arthur Gooding.

Dr. Gretchen was born and brought up in Columbus, where she attended the College

of St. Mary of the Springs. She received a B.A. degree *magna cum laude*.

During her years of medical study, Dr. Gretchen was chosen for membership in Alpha Omega Alpha and Kappa Gamma Pi, a national honor society. She has held the presidency of the Landacre Society and of Alpha Epsilon Iota in addition to that of (Ohio State's) AMWA Junior Branch.

The Drs. Gooding have remained in Columbus, where Dr. Gretchen is interning at the University Hospital.

MARGARET LOUISE WYATT, M.D., one of 6 women in a class of 73 students, graduated in the top ten per cent of her class from the Medical College of South Carolina, Charleston.

A tradition of medical and related careers is evident in Dr. Wyatt's family: Her father, Dr. Charles N. Wyatt, is past president of the South Carolina Medical Association; her mother is a graduate nurse; and her brother works for a pharmaceutical company.

Dr. Wyatt earned her B.S. degree at the College of William and Mary, Williamsburg, Va. She is now interning at the University of Virginia Hospital in Charlottesville.

Beach and water sports, movies, and dancing are Dr. Wyatt's hobbies.

These nine coeds, the first women ever admitted to Jefferson Medical College, Philadelphia, started classes Monday, September 11, in Jefferson's 138th session.

Front row: *Left to Right.* Miss Joyce E. Price, Altoona; Mrs. Amilu S. Martin, Philadelphia; Miss Nancy S. Szwec, Clifton Heights, Pa.; Miss Carolyn E. Parry, Dresher, Pa.; Miss Bette-Lee Jarvis, Merion Station, Pa.

Second row: *Left to Right.* Miss Merle P. Gross, Philadelphia; Miss Carol A. Miller, Cleveland; Miss Mary E. Knepp, Stroudsburg; Miss Margaret Libonati, Philadelphia.

Opportunities for Women in Medicine

AWARDS

Physical Medicine and Rehabilitation. Residents, interns, and medical students are invited to enter a prize essay contest sponsored by the Louis Lefkoe Memorial Foundation for the Pennsylvania Academy of Physical Medicine and Rehabilitation. The Lefkoe award of a plaque and $150 in cash will be presented at the spring meeting to the author of the most deserving original essay on physical medicine and rehabilitation. Basic research, clinical research, clinical work, or case reviews may be the source of material, but the essay must not be a review of the literature. Manuscripts must be submitted in triplicate to the chairman of the committee by Feb. 15, 1962. For further information, write Dr. Emery K. Stoner, Hospital of University of Pennsylvania, Department of Physical Medicine, 3600 Spruce St., Philadelphia.

Research. BRANCH TWO, CHICAGO, ILLINOIS of AMWA is sponsoring a contest for original research papers by both men and women in the Midwest. Send requests for information and application forms to Dr. Bertha L. Isaacs, 670 Michigan Ave., Chicago, Ill. Manuscripts must be submitted to her by Feb. 1, 1962. Cash prizes of $100 and $50 will be awarded and the winners will be announced at the April meeting of Branch Two at the Mary Thompson Hospital.

COURSES

Diabetes. The American Diabetes Association announces the program for the Tenth Postgraduate Course, "Diabetes in Review: Clinical Conference, 1962," to be held January 17, 18, and 19 in Detroit and Ann Arbor, Mich. The sessions of the first and third days (Wednesday and Friday), Jan. 17 and 19, will be at the Statler Hilton in Detroit, which will serve as headquarters. The second day's lectures (Thursday), Jan. 18, are scheduled at the University of Michigan, Ann Arbor. Wednesday, Jan. 17, will be devoted to "Fundamental Considerations" and "Pathogenesis," which will conclude with a panel discussion on "Diabetes and Prediabetes—Pathogenesis and Prevention." The Thursday sessions at Ann Arbor will cover "Insulin Assay—Antagonism and Acidosis" and "Related Metabolic Problems." Friday morning, Jan. 19, the general topic, "Treatment of Diabetes Mellitus," will also include two panel discussions: "Problems in Management of Brittle Diabetes" and "Pregnancy and Diabetes." The luncheon address, "Myocardial Metabolism in Diabetes," will be given by Richard J. Bing, M.D., Chairman of the Department of Medicine, Wayne State University College of Medicine. "Complications of Diabetes Mellitus" followed by a panel discussion on the subject will take place on the final afternoon of the course. Dr. Charles H. Best of Toronto, co-discoverer of Insulin, will present the closing lecture, "Present and Future Research Problems in Diabetic Mellitus." The American Academy of General Practice will give 19 hours of Category II Credit for the three-day course, which is open to Doctors of Medicine. The fee is $40 for members of the Association and $75 for nonmembers. All registrants will be guests of the Association at a banquet to be held Wednesday evening, Jan. 17. For further information and registration forms write to: American Diabetes Association, 1 East 45th St., New York City 17.

Internal Medicine. The American College of Physicians offers Postgraduate Course No. 5, "Internal Medicine—Today's Problems in Diagnosis and Management and Tomorrow's Projections," to be held Jan. 15-18 at Ochsner Foundation Hospital New Orleans. For additional information write to Edward C. Rosenow, Jr., M.D., Executive Director, ACP, 4200 Pine St., Philadelphia 4.

Medical Genetics. The American College of Physicians Course no. 6, "Medical Genetics," will be offered at the University of Michigan Medical School, Ann Arbor, Jan. 29-Feb. 1, 1962. The course will attempt to present a bird's-eye view of contemporary medical genetics. Also discussed will be: chromosomal abnormalities, the hemoglobinopathies, idiosyncrasies to drugs, individual variations in serum proteins, errors of intermediate metabolism, abnormalities of connective tissue

and the gastrointestinal system, and hereditary syndromes. Due to a limited registration, forms must be sent in as soon as possible and may be obtained from Edward C. Rosenow, Jr., M.D., Executive Director, ACP, 4200 Pine St., Philadelphia 4.

Obstetrics, Cardiology, and Pre and Postoperative Care. The Medical College of Georgia is offering three postgraduate courses in 1962. "Obstetric Problems in Private Practice," Jan. 23-25; "Cardiac Emergencies," Feb. 13-15; and "Pre and Postoperative Care," March 20-22. Louis A. Goldstein, M.D., Associate Professor of Surgery (orthopedics), University of Rochester School of Medicine, Rochester, N.Y. will be on the faculty. For more information write to: Claude-Starr Wright, M.D., Director of the Department of Continuing Education, Medical College of Georgia, Augusta.

MEETINGS

Congenital Defects. The International Medical Congress Ltd. announces the first Inter-American Conference on Congenital Defects which will be sponsored by the National Foundation and the University of Southern California. The Conference will be held at the Statler Hotel, Los Angles, Jan. 22-24, 1962. The program will cover three topics: Genetic Effects, Structural Defects, and Clinical Manifestations of Genetic and Structural Defects. For further information write Stanley E. Henwood, Executive Secretary, International Medical Congress, Ltd., 120 Broadway-Room 3013, New York City 5.

SYMPOSIUM

Oncology. The annual symposium on Fundamental Cancer Research will be held March 1-3, 1962 at the University of Texas, M.D. Anderson Hospital and Tumor Institute, Houston. Its central theme will be Conceptual Advances in Immunology and Oncology. Felix Haas, Ph.D., symposium chairman, gave as topics to be discussed: theories of antibody production, cancer-specific antigens, the genetic basis of immune response, metabolic control of antibody synthesis, and the nature of the antigen-antibody reaction.

Letters From Other Desks

Catharine Macfarlane, M.D.
Philadelphia

Dear Dr. Macfarlane:

I was flattered and pleased to find your letter of May 3rd awaiting me when my husband and I returned from Brazil. I would have been delighted to serve on the Nominating Committee had circumstances not prevented. I have the greatest admiration for you and although we meet infrequently, you have been an inspiration through the years.

You may have heard that, to everyone's great surprise (including mine), I was married last November to a prince of a man, Jonathan Garst, Ph.D., an agronomist. He was sent to Brazil on a presidential mission in March. While we were traveling in Brazil I met quite a few of the women doctors. The one who seemed to know you best and was full of admiration for you was Dr. Hildegard M. Staltz in Rio de Janeiro. She struck me as an outstanding obstetrician-gynecologist. She is also an excellent teacher and upholds high standards.

We expect to go back to Brazil in a few weeks. I am studying Portuguese and cytology. They could use more experts in this latter field.

My very best wishes and kindest regards.

Sincerely,

Gertrude F. Jones Garst, M.D.
San Francisco

MEMORIAL TO EMILY DUNNING BARRINGER (1877 - 1961)

Dr. Emily Dunning Barringer, a champion of women physicians' rights and the first woman to serve on the staff of a general municipal hospital in New York City, died on April 8, 1961, at the age of 84.

A native of Scarsdale, N.Y., her career began when she enrolled in Cornell University, from which she graduated in 1897. She then attended the medical college of New York Infirmary. She transferred, after two years there, to the medical school of Cornell University, when it started admitting women students. Receiving her medical degree in 1901 she had to wait two years to obtain her first appointment. The other interns protested her application for Gouverneur Hospital, the downtown branch of Bellevue Hospital. They said the district was too tough for her, that she could not handle the bums in the Bowery saloons.

She was 27 at the time of her appointment, a triumph for her as a woman as well as a physician. She hung on to her post there as she hung on to the strap in the back of the ambulance when it went hurtling down the streets between tenement houses, banks of snow, and gas lamps. Setting broken bones and mending heads from Chinatown to Williamsburg Bridge, being followed by children from the slums yelling and throwing stones, and climbing five flights of steps to reach the sick and dying characterized her first year as a physician. In so doing she won the respect of the policemen, the workers, and the children.

After her internship she held positions as director of gynecology at Kingston Avenue Hospital, Brooklyn, N.Y. and as consultant in obstetrics and gynecology at the New York Infirmary for Women and Children. For a few years she was on the staff of a clinic in Vienna, Austria.

As chairman of an AMWA committee she was instrumental in obtaining commissions for women physicians in the medical corps of both the Army and the Navy during World War II.

Working in a related field she tried to have laws passed for the control of venereal diseases. At one time she was chairman of the committee on minimum standards for delinquent girls of the National Committee on Prisons and Prison Labor.

In addition to her articles written on gynecology she wrote her autobiography, "Bowery to Bellevue."

She was President of the New York Medical Women's Association, a member of the AMA and a Fellow of the American College of Surgeons, the New York Academy of Medicine, and on the Medical Advisory Board of the American Social Hygiene Association.

Her husband was the late Dr. Benjamin Stockwell Barringer, surgeon and head of the Urological Department of Memorial Hospital, New York City.

—Camille Mermod, M.D.

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*Book review
†Letter

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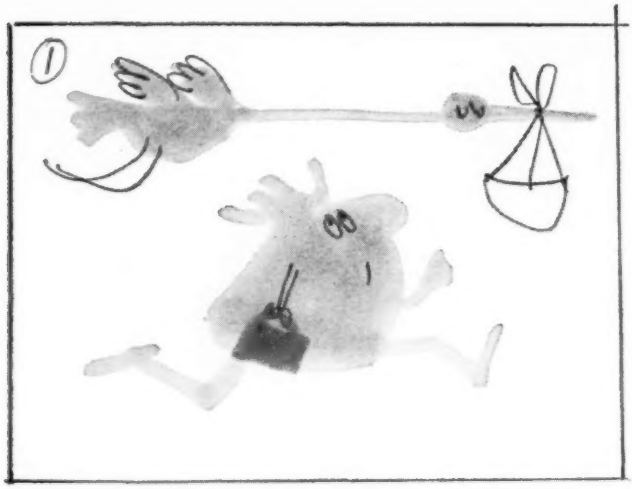

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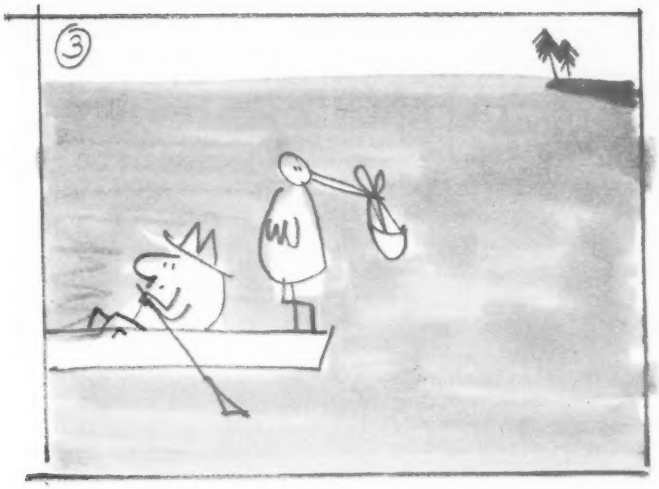

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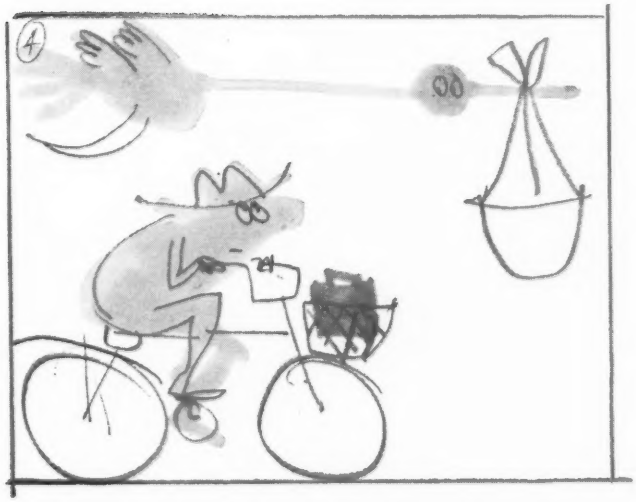

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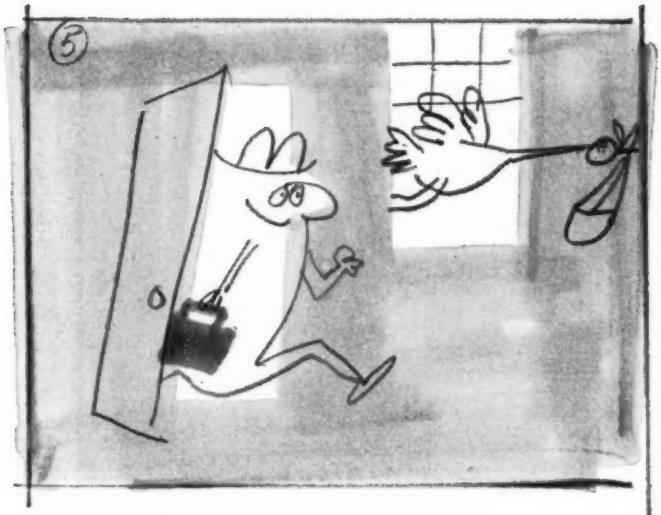

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What age should babies start taking fluoride?

now is the time (the earlier the better) to protect his permanent teeth

The earlier in life you start fluoride the greater the benefits.
No time like the present.

Extensive evidence from studies in areas with fluoridated drinking water shows that the incidence of dental caries may be reduced as much as 60% in resident children compared to controls not receiving fluoride.

And—the younger the child at the time fluoridation is started, the greater the benefits. Because hard tooth substance begins to form at the embryonic age of about twenty weeks, fluoride should be administered as early in life as possible, if decay-resistant tooth enamel is to be achieved. *Adeflor supplies fluoride with routine pediatric vitamin supplementation and costs no more than vitamins alone.*

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Costs no more than vitamins alone.

Brief Basic Information

Formula:

Each 0.6 cc. of Adeflor Drops contains:

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Vitamin D_3	(1000 units) 25 mcg.
Ascorbic Acid (C)	50 mg.
Pyridoxine Hydrochloride (B_6)	1 mg.
Fluoride (as sodium fluoride)	0.5 mg.

Indications: As an aid in the prevention of dental caries and in the prophylaxis and treatment of deficiencies of Vitamins A, C, D, and B_6.

Dosage and Administration: Where the drinking water is substantially devoid of fluoride, infants and children may be given 0.6 cc. Adeflor Drops daily.
May be administered by dropping directly on the tongue or by mixing with water, milk, fruit juice, or food.

Precautions and Contraindications: The use of this product is recommended only in areas where the fluoride content of drinking water is known and is less than 0.7 parts per million.

Supply: 15, 30, and 50 cc. plastic bottles with a plastic, calibrated (0.6 cc.) dropper. Available on prescription only.

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Withdrawal bleeding rare,[1-3] since TACE, stored in body fat, is released gradually, even after therapy is discontinued.

Dosage:
4 capsules daily for 7 days.

Supply:
Capsules containing 12 mg. TACE.

References:

1. Eichner, E., *et al.: Obst. & Gynec. 6*:511, 1955. 2. Bennet, E.T. and McCann, E.C.: *J. Maine M.A. 45*:225, 1954. 3. Nulsen, R.O., *et al.: Am. J. Obst. & Gynec. 65*:1048, 1953.

Brochure with full product information available on request.

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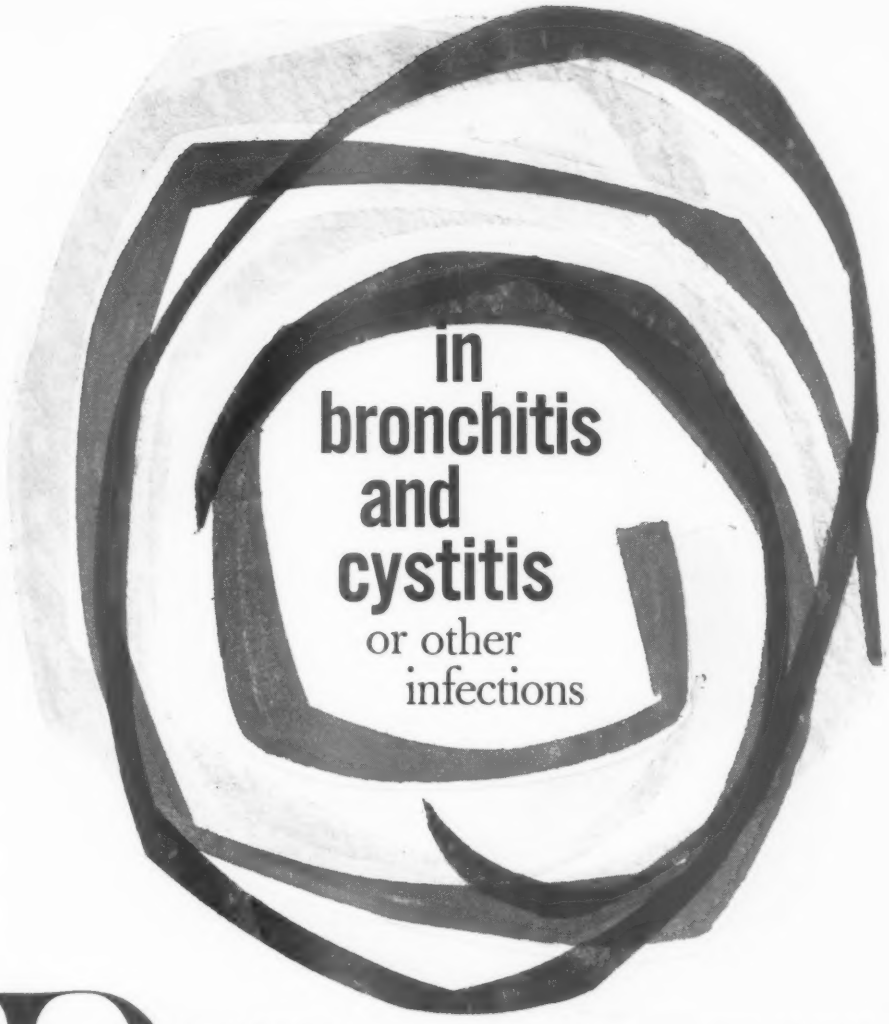

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1. Lipp, R.G.: Habitual Abortion—Treatment with Parenteral Medroxyprogesterone Acetate, to be published.

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Brief Basic Information

	Description	Indications	Dosage: Threatened abortion	Dosage: Habitual abortion	Supplied	Precautions
Oral Provera*	Upjohn brand of medroxyprogesterone acetate.	Threatened and habitual abortion, infertility, secondary amenorrhea, functional uterine bleeding.	10 to 30 mg. daily until acute symptoms subside.	1st trim. 10 mg. daily 2nd trim. 20 mg. daily 3rd trim. 40 mg. daily, through 8th month.	2.5 mg. scored, pink tablets, bottles of 25; 10 mg scored white tablets, bottles of 25 and 100.	Clinically, Provera is well tolerated. No significant untoward effects have been reported. Animal studies show that Provera possesses adrenocorticoid-like activity. While such adrenocorticoid action has not been observed in human subjects, patients receiving large doses of Provera continuously for prolonged periods should be observed closely. Likewise, large doses of Provera have been found to produce some instances of female fetal masculinization in animals. Although this has not occurred in human beings, the possibility of such an effect, particularly with large doses over a long period of time, should be considered. Provera, administered alone or in combination with estrogens, should not be employed in patients with abnormal uterine bleeding until a definite diagnosis has been established and the possibility of genital malignancy has been eliminated.
I. M. Depo-Provera*	Each cc. contains: Medroxyprogesterone acetate, 50 mg., Polyethylene glycol 4000, 28.8 mg.; Polysorbate 80, 1.92 mg.; Sodium chloride, 8.65 mg., Methylparaben, 1.73 mg., Propylparaben, 0.19 mg.; Water for injection, q.s.	Threatened and habitual abortion.	50 mg. I.M. daily while symptoms are present, followed by 50 mg. weekly through 1st trimester or until fetal viability is evident.	1st trim. 50 mg. I.M. weekly 2nd trim. 100 mg. I.M. q. 2 wks. 3rd trim. 100 mg. I.M. q. 2 wks. through 8th month.	Sterile aqueous suspension for intramuscular use only, 50 mg. per cc., in 1 cc. and 5 cc. vials.	

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80%
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in 25
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with
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myo- -vascular relaxant

provides direct, non-hormonal action on the myometrium to relieve painful uterine spasm or hypermotility

VASODĪLAN does not disturb normal menstrual rhythm or flow[1,2]...and can be prescribed safely with other therapies.[2]

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In one double-blind study,[1] good to excellent relief of severe menstrual cramps was noted in 79 per cent of the patients. Another investigator[3] notes satisfactory relief of dysmenorrhea in 83 per cent of the cases studied.

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Supplied: 10 mg. tablets, bottles of 100; 2 cc. ampuls (5 mg./cc.) for intramuscular use, boxes of 6.

References: (1) Ratowsky, S., and Padernacht, E. D.: Clin. Med. *8*:512-514 (March) 1961. (2) Voulgaris, D. M.: Dysmenorrhea: Cramps or Psyche?, Scientific Exhibit, Am. Acad. G. P., Philadelphia, March 21-24, 1960. (3) Voulgaris, D. M.: Obst. & Gynec. *15*:220-222 (Feb.) 1960.

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